Implications of Private Sector involvement in providing health care to the Elderly, *Now and in the New Millennium*

A thesis

submitted in fulfilment of the requirements for the Degree

of

Master of Arts in Political Science

in the

University of Canterbury

by

Andrew James Shead

University of Canterbury

1998

In Memoriam
Wilford James Mayne (1905-1963)
Melva Mable Mayne (1908-1995)

Contents

Abstract

This thesis investigates the impediments to access engendered by the government's decision to reduce public funding to health care and incorporate market principles in the financing process. The critique begins with competitive markets and their application to the provision of health care. The intent is not to argue along the lines of 'state verse the market' but rather to explicate the fundamental changes which are going on in the thinking of government and policy makers today in respect to their approach toward providing health care. Against this background the implications of these fundamental changes are assessed on a rapidly growing group in New Zealand, the elderly.

An empirical study of the elderly is conducted in order to validate both the micro and macro issues raised in this thesis. The macro issues focus on the effectiveness of market reforms and the issue of access for the elderly, while the micro issues relate to the reality of private sector involvement for the elderly.

The conclusions to be drawn from the thesis are threefold. First, the involvement of the private sector in providing health care has created fundamental access problems for the elderly. If the current political mandate in health care is followed then this will manifest into an even greater problem in the next millennium. Second the reduction of the state's role in financing health care is creating uncertainty and financial pressure on the elderly. Third, the private insurance market is not suitable as a provider of essential health care services required by the elderly in New Zealand.

Acknowledgments

I would like to thank Dr Bob Blank for his guidance and humour in seeing this thesis to its conclusion. Dr Joanna Goven for her editing work and stimulating political conversations on this topic and others related to it. To those staff and lecturers in the Political science department, Jill and Phillipa, Richard Kennaway, Richard Jackson, Jim Ockey, James O'Connor and Ron MacIntyre.

Also those second year masters students for their very useful and very important advice - Jason Moody, Phil Clark, Steve Church, Amber Balanchi. A special thanks to the very talented Gretchen Scott for her proofing, her input and her company throughout this very solo year.

Age Concern for their generosity with their natural resources, the elderly who filled out surveys and gave me interviews and the Insurance companies who did the same.

Figures

Page

Tables

Introduction

In the early 1990s, New Zealand's health system, which was established in 1938 and based on a model of social equity, under went a fundamental reformation. It was reinvented with a contemporary economic structure based on competitive markets and sold to the public on the premise of greater efficiency and equity for all. The macro objective was to reduce the role of the government in social policy areas in order to get the economy back on track. This was to be achieved by returning a surplus to the country's economic budget and paying back its crippling overseas debt. The strategy was to integrate the private sector with that of the public and jointly provide the increasing demand of health care resources to the population. What has materialised is that the government has withdrawn from the provision of certain essential services, relying on the private sector to fill the void.

With the increased privatisation of the once very public domain of health care, the move from a social equity model to one based on market-competition has had major implications for health care providers, patients, low socio-economic groups, the state as a whole and other groups in society. This thesis does not take a general swipe at the impacts the private sector is having on health care. Rather, it aims to investigate the implications of opening up health care to the market on major aspects of provision to an increasingly important group in New Zealand's society, the elderly. [1]

The primary objective of this thesis is threefold. First, at a wide level of generality an examination is made as to the implications of changing from a 'social equity model' of financing health care to one based on 'market competition' for the elderly in society. Second, at a narrower level of generality an assessment is made as to the ability of the elderly under the new financing model to adequately access health care under the government's

[1] It is increasingly important due to the fact that population estimates of elderly in New Zealand in the first two decades of the new millennium are projected to rise by 16.5 percent from current levels today, a trend which is in line with other countries, as cited in *New Zealand Now 65 Plus, Statistics New Zealand*, Wellington, New Zealand, 1995,p14.

directives of private sector provision. Third, this thesis examines the ability of the private sector to provide for this group now and in the future when many more New Zealanders will be over the age of 65.

Controversy and public dissatisfaction has surrounded the government's move to reform New Zealand's health system. Much of it flows from the lack of support from the medical professionals. While the reform process has been slowed due to public dissatisfaction, the current coalition government has no intention of abandoning its path of state withdrawal and private sector incorporation. While those persons on the Business Roundtable argue that the reforms have not failed - they have only experienced a few expected teething problems - others, including those who work in the health sector administrators and medical professionals, say that the adoption of the competitive model to finance health care has inherent problems which are having serious impacts on society today. These will only worsen if the current direction in health does not change. Reforms to the health care system were implemented for the benefit of the economy, in fact some economists claimed they were essential for an economic recovery. However, serious problems regarding the ability to access much needed care is beginning to emerge. Much can be attributed to the government's withdrawal from financing and its replacement by the private sector. The most critical element is the role that the private sector now plays in the provision of health care. The specific focus in this thesis is on the ability of the private insurance market and in particular the private insurance companies to be able to provide the necessary health care required by the elderly, as their numbers rise in the new millennium.

With this focus two hypotheses are postulated, first, the governments shift from a 'social equity model' in health care provision to one based on 'competitive markets' has created fundamental distributional concerns which favour certain minority groups and disadvantage others, namely the most rapidly growing in New Zealand - the elderly. Second, access is becoming increasingly difficult due to the incorporation of the private sector and the withdrawal of the state involvement in financing health care. Consequently if the current health care mandate of the government is continued into the next millennium then New Zealand's largest growing population group will have limited access to essential health care.

The first chapter comprises the theoretical core of the thesis. It critiques the arguments which fuel the debate surrounding the presence of market competition in financing the health care system. The review is concentrated on the theories of Donald and Gerard and Harris and Seldon which conflict with arguments raised by Scott and Evans. The purpose is to critique the competitive market approach per se and then to assess the issues which arise when applied to the environment of health care. A review of the various types of financing models used by OECD countries is undertaken in order to compare and contrast various financing options available to policy makers.

Chapter two examines which financing options have been adopted by various countries and compares the system used to the proportion of public and private spending by those countries. The purpose of this is to place New Zealand's chosen position in a international context.

Chapter three critiques the arguments from both health professionals and health economists surrounding the reforms to New Zealand's health care system which will provide the contextual background to this dynamic environment at the same time the government's justification for the reforms, such as the world wide drive for privatisation, is examined and it is revealed that restructuring the welfare state is a global phenomenon. Reforms to health in New Zealand are part of a much larger pattern of upheaval and transformation of political, economic and social relations. In addition, the ideology of the National party is studied and neo-liberalism is identified as the catalyst behind the reforms. The final part of this chapter assesses the direction of the coalition government towards health and, in particular, towards the care of the elderly.

Chapter four examines the impacts to the elderly as a result of changes to the health system through market incorporation. It is argued that the private sector, in particular insurance companies, is an increasingly important provider of health care services but it has a number of fundamental failings which are affecting the elderly now and are highly unlikely to improve in the future. It is postulated that if the coalition government continues shifting the financing of New Zealand's health care system to the private sector while effectively reducing the states role of social responsibility, this will result in increasing financial pressure and

continuing uncertainly for the elderly, now and in the future. For this purpose, an empirical study of the elderly's experience with the health system is undertaken.[2] This then allows an analysis of impacts resulting form private sector involvement.

The last chapter deals with the questions arising from the macro issues in this thesis which are drawn from the theories in chapter one. Using evidence from the case study the arguments advanced by both sides are tested. Further, at the macro level the nature of the public policy transformation is probed with an emphasis on the experimental nature of the policy shift. It is postulated that private insurance companies are not suitable for providing the elderly with the necessary health care that they require. The existence of moral hazard and adverse selection are investigated within insurance companies with an assessment made as to whether the private sector is capable of providing for the health care needs of the elderly in the new millennium.

There are a number of goals which have motivated the writing of this thesis. The emphasis is primarily focused on the belief that there is an essential need for empirical research on the fundamental dynamics of private sector involvement in areas which involve social policy. The reasons for this should be evident with the private sector playing an increasingly larger role in the provision, supply and distribution of essential resources in this country and others. The issue lies in the fact that there is scant evidence as to the actual effectiveness of competitive markets in health care. The American system is fraught with warnings and the concern is that New Zealand's health system is going to develop many of the negative elements which have formed in that country.

It must, however, be pointed out that competitive market involvement in health care can, and indeed does, have a place . The issue is whether the private providers are capable to supply health care resources in a way that the elderly can afford. After all health care is an industry with unique characteristics. The life and wellbeing of every individual in the community will, at some time or other, be dependent on the quality and affordability of its services. If these are controlled privately then they must be accessible.

---

[2] Refer appendix A for the questions asked, and for comments made.

In this respect this thesis will investigate an area of increasing interest and importance to New Zelanders - the integration of private and public involvement in the provision of health care services. Professor Ham[3] contends that the priority is for the public and private sectors to work more effectively together in the future. To consider either public or private finance alone as superior is a sterile debate. The integration of the two is here to stay. Ham purports that continuing with a large measure of public funding of health care with private finance existing as an important supplementary source of finance is important. Ultimately, however, who manages a hospital, or who runs the services does not matter as long as the patients are getting the standard and the quality of care they need. The question is whether this goal is being met under the current arrangements.

As important as it is to clarify the focus of this thesis, so too is it important to clarify what is outside its scope. It does not deal with every issue which might be deemed to impinge on the health of the elderly as there are many factors which are involved, such as lifestyle (diet, social behaviour, smoking and drinking, inactivity), social class, and ethnicity. Unlike reports such as 'Care for Older People in New Zealand,'[4] this paper is not about assessing what the elderly need on a micro scale. Nor is it about evaluating and critiquing the quality of services provided by the private sector. This thesis is interested in whether or not the elderly will be able to gain access to essential health care resources which are controlled by the private sector under the new competitive market model. This study combines quantitative and qualitative method, in its collection, analysis and presentation of data. Quantitative data from the survey was gained by conducting 230 surveys of the elderly, of which 45 percent of surveys were done in the North Island, predominantly in and around Auckland city and suburbs. The other 55 percent were conducted in and around Christchurch. The data were collated and converted into various graphical representations. Half the survey sample was taken randomly from the telephone directory. The other half was interviewed randomly in person. Further methodological details are given in Appendix A.

---

[3] Professor Chris Hams, who is Professor of health quality and management at the university of Birmingham, and director of the university's health services management centre.
[4] Written in 1995 as advice for the National Advisory Committee on Core Health and Disability Support Services.

The findings of this study confirm that if the current involvement of the private sector continues unabated then New Zealand's largest growing population group (those over 65) will have limited access to essential health care. This is evidenced by three factors. First insurance premium rises are driving the elderly to either scale down their cover or cancel there policies altogether, which leaves them reliant on an ill equipped public system. Second, the clustering of private facilities in only the economically viable areas is creating geographical maldistribution concerns. Third, the numbers of elderly are rapidly growing creating further stress on an overworked public system.

The study confirmed that the government's shift from a 'social equity model' in health care provision to one based on 'competitive markets' favours certain small minority groups such as those with high incomes and few dependents, while disadvantaging the largest group, the elderly. This was evidenced by the transferring of costs from the higher socio economic group to the lower through a reduction in social policies and a reduction in taxes which in effect transfer costs directly to the elderly.

Most significantly the study found that private insurance companies are not suitable for providing the elderly with the necessary health care that they require. This was evidenced by the major distributional concerns in the form of price discrimination and market adaptation beneficial to the industry. This then results in the formation of a two tier system of health care - one for the wealthy and one for the poor.

As a result of these findings, it is suggested that the government reassess the level of control the private insurance markets have, and provide a reasonable level of core services available to the elderly, rather than exclaiming this task as being to difficult. Yet such a reassessment brings with it troublesome social problems, not all are health-related, but to ignore those that are, is at great cost to the country's health and social services. This is not to dispute the urgency to initiate long term planning now, and to prepare for future pressures on the health system as the population ages, but it is imperative that policy makers ensure that the elderly have access to essential health care resources, and are not left to fend for themselves in the market driven environment of the private sector.

CHAPTER ONE

Theory of Market Competition in Health Care

In recent years there has been a surge of interest in reforming health care systems by replacing government regulation with competitive market forces. Although much of the impetus has come from the United States, the phenomenon is worldwide. Spurred on by ever-increasing health care costs, many analysts and policy makers have embraced the competitive market as the method of choice for reforming health care. This belief stems from economic theory, which purports to show the superiority of markets over government regulation.[1]

Political conflict over the respective roles of the state and the market in health care has a long history. The current incorporation of the private sector and market principles into New Zealand's health care system represents the resurgence of ideas and arguments that have been promoted with varying intensity throughout the 20th century. Indeed, international experience over the last forty years has demonstrated that greater reliance on the market is associated with inferior system performance, inequity, inefficiency, high cost, and public dissatisfaction.[2] The United States is the leading example. So why is this issue being introduced and embraced by New Zealand policy makers as a prudent way of financing health care? The short answer is a combination of internal pressures, such as high costs, budget deficits and large social spending, and external pressures, namely international pressure from the IMF and World Bank economists.

The popularity of incorporating market principles into health care is evident in the fact that the traditional economic model of competition has a strong grip on influential health economists around the world. However, a 1989 survey of health economists in the United States and Canada demonstrates that the validity of the market in health care is controversial.[3]

---

[1] T.Rice 'Can Markets Give Us the Health System We Want?', UCLA School of Public Health, in *Journal of Health Politics, Policy and Law*, Duke University Press, Vol22, No.2, April 1997,p383.

[2] R.G.Evans, Going for the Gold: 'The Redistributive Agenda behind Market-Based Health Care Redorm', *Journal of Health Politics Policy and law,* Duke University Press,Vol.22, No.2, April 1997,p.453.

[3] Feldman, R., and M.A. Morrisey. 1990. Health Economics: A Report on the Field. *Journal of Health Politics, Policy and Law* Vol 15, Pp.627-646.

One of the questions asked by the survey was whether the competitive model could apply to a health care system. Respondents were evenly divided on this question; half thought the model could apply, and half did not. Interestingly, the respondents who advocated the competitive model had a purely economic background with no history of social policy experience. Similarly, in his recent survey of health economists, Victor Fuchs found a great deal of agreement on so-called positive issues, but very little on normative ones, which would presumably include whether health economists believe that the competitive model should be applied to the health care market.[4] There is, therefore, no unified agreement amongst health economists as to whether the competitive model is an appropriate means for studying and perhaps reforming health care systems.

The intent of this thesis is not however, to argue along the lines of 'state versus the market' in providing health care, but rather to investigate what impact and implications are resulting due to the incorporation of the private sector into health care on the most rapidly expanding group in New Zealand - the elderly. The purpose of this chapter is to identify the economic theory behind the competitive market model and to assess arguments for and against it. Following this, potential failures of the private insurance market (PIM), which is becoming the most important sources of health care provision, are reviewed.

Before launching into an analysis of health care markets, it is imperative to understand that there are several elements which combine to make up a health care market. One such element is for the supply of health care services by health care professionals. Another is for products such as pharmaceuticals and equipment. There is also a market for the financing of health care. On a macro scale this includes a set of market-like instruments or arrangements which include privately owned or managed institutions, and can range from stockholder-owned insurance companies to non profit sickness funds in the German tradition. It is this wider private insurance market (PIM) which is to be the focus of this study due to the growing importance of the insurance companies role in providing health care to society, in particular the elderly.

Incorporating market competition into the health system means access to care is determined largely on an ability to pay. Providers of care are directly rewarded according to market forces mainly through fee for service payments.[5] Hence, on this approach, the consumer is sovereign and health care is based on demand expressed through the market, whereas in the 'social equity model' health care is based on need with resources being distributed primarily on grounds of equity. Equity is the sacrifice when one places the burden of paying the full cost upon the immediate recipient as a fundamental issue of access to health care is created.

---

[4] Fuchs,.V.R. 'Economics, Values, and Health Care Reform', *American Economic Review*, 1996,Vol1-24, Pp. 86.

[5] Klein R, *Private pactice and public policy: regulating the frontiers*, 1982, as cited in McLachlan, G and Maynard.A, *The Public/Private Mix for Health*, NPHT, London, 1982,Pp.95-128.

> 'the USA experience has shown that significant numbers of people miss out on health care because they cannot afford private health insurance and they earn too much to qualify for state assistance. Hence, under a competitive market system, services will be provided only to those who can afford to pay. This means that some groups in society will receive inadequate health care unless the equity problem is addressed in some way. If equity is a goal of society, then an element of government involvement is necessary to intervene even if to do so necessitates a trade-off between equity and efficiency.'[6]

Those who argue that health care is best funded through the market see the market model having a number of advantages which reflect the assumption that health care is an ordinary commodity. These advantages include

- greater responsiveness to consumer preferences, contributing to innovation and equal treatment.
- greater equity through rationing by price
- more flexibility and an expansion of hospital-based services.
- the removal bureaucratic inefficiency and greater consumer and provider responsibility.[7]

However, Evans contends that because market mechanisms yield distribution advantages for particular influential groups, a number of problems result, such as

- A more costly health care system yields higher prices and incomes for suppliers, physicians, drug companies, and private insurers.
- Private payment distributes overall system costs according to use (or expected use) of services, costing wealthier and healthier people less than finance from (income-related) taxation.
- Wealthy and unhealthy people can purchase (real or perceived) better access or quality for themselves, without having to support a similar standard for others.[8]

Evans states that there is, and always has been, a natural alliance of economic interest between service providers and upper-income citizens to support shifting health financing from public to private sources.[9] These arguments will be examined in part two of this thesis.

While many of the techniques used by economists are fairly new, the emphasis on competition is not, dating back to the writings of Adam Smith over two hundred years ago. Smith believed that people, driven by their own economic interest in the marketplace are guided by an 'invisible hand' to act in a manner that is ultimately most beneficial to society at large.

---

[6] Scott G, Health in the marketplace, *Health Reforms a second opinion*, Wellington Health Action Committee, 1992,p.17.

[7] Harris.R and Seldon.A, *Not from Benevolence*. Institute of Economic Affairs, London 1977,as cited in B.Hindess, 'Political Choice and Social Structure': *An Analysis of Actors, Interests and Rationality*. Elgar/Gower, Brookfield, 1989.

[8] Harris & Seldon, *Not from Benevolence*,1977.

[9] Harris & Seldon, *Not from Benevolence*,1977.

In a competitive market people are allowed but not compelled to trade their stock of wealth, including their labour, to purchase goods and services. Firms are compelled to produce only those things that people will be willing to purchase, and to do so in the least costly manner. The market reaches equilibrium when demand matches supply, there is no surplus hence no waste and no shortage. Such an outcome is desirable for several reasons: people are making their own choices, the only goods and services produced are those that people demand, and they are produced without wasting resources. Because of this the notion of competition is intuitively appealing. There are, however, a number of variables at work in a market, in particular, elasticity of demand, or to put it another way, the responsiveness of consumers to price change. For a commodity that is a luxury good, for example European cars, if the price increases it is likely that the demand for them will decrease, therefore, it could be said that demand for European cars is elastic. Health care is a necessity so, theoretically, if prices rise demand will remain the same. This means that those who supply health care are in a very advantageous position, especially if there are only a few suppliers. This is one of the major reasons why much regulation is needed in a health care system which is opening itself up to market mechanism.

The above demonstrates that the simple-minded application to health care of economic theories about competitive markets is more complex in its nature due to external variables. Analysts across the spectrum of opinion reject the simplistic dichotomies of government versus the market, or regulation versus competition.[10] More pertinent are questions concerning the impacts and implications of market competition on specific groups in society and their effects. It is not hard to find academics in the field of economics that are critical of the value of markets in health care. Scott contends that competition and a free and uncontrolled health care market will fall short of providing the health care society wants for the fundamental reason that in order for the market system to function effectively the consumer must have knowledge of;

- their existing health status,
- the relevant treatment and prevention options available,
- competence of providers.[11]

Most consumers do not have this knowledge or have only partial knowledge and must rely on the supplier of health care to provide it. However, providers are not enthusiastically moving to remedy this imbalance as 'commercial sensitivity prevents both the sharing and the dissemination of information.'[12] Moreover, the fact that providers have more information than consumers offers providers the opportunity to capture and control the system by over-servicing those consumers able to pay and supplying the mix of service that suits the provider, rather

---

[10] Health Care Study Group 1994,'Understanding the Choices in Health Care Reform'. *Journal of Health Politics, Policy and Law*, Vol.19,1994, p.499.
[11] Health Care Study Group 1994.
[12] Health Care Study Group 1994.

than the consumer. Admittedly this can occur under a government-funded and provided system as well, but there is a greater potential for it to occur under free-market conditions where government monitoring, intervention and controls may be minimal.'[13] Therefore, government intervention is essential to ensure that the consumer is safeguarded against dangerous and ineffective treatments, and provided with sufficient information to make a choice. It is a fallacy to assume that there should be fewer regulations and controls in a competitive market, as the private sector requires government intervention for solutions which are compatible with societal goals. Any gains from competition must be balanced against the additional cost of regulation and control. This does not mean that the state should necessarily be the dominant provider of health care, but it is essential that the state regulate and provide funding for those individuals unable to pay for essential health care. An unregulated market will not result in an economically efficient or socially equitable provision of health care.[14]

The government has been reducing public funding in health care over the last 17 years (as addressed in chapter 3). The reforms in the early 1990s have encouraged markets, in particular PIM, to provide health care resources to individuals. Other means of funding withdrawal, such as rationing health care resources in the form of waiting lists and user pays, has always existed amongst much controversy. Rather, it appears that the government has opted for fundamental change, such as running down the public health care system by reducing expenditures and opening the way for the private insurance market, in order to ration public resources.

Historically, many countries have determined that market failure in health care was too severe so a large proportion of services continue to provided by the central government.[15] Even in the most market-oriented economies a common, everyday commodity like food is subjected to some level of government intervention in its financing, and sometimes in its provision. On the demand side of the market, income subsidies are provided to certain groups of people to give them the ability to purchase the basic necessities of life, like foodstuffs. Once consumers have been subsidised and producers inspected, they are free to make transactions between one another in a largely unregulated environment. It is assumed that consumers are the best judges of their own welfare. However, in health care government intervention is much more extensive than this. Intervention in the health care market often involves governments purchasing care on behalf of consumers and even providing such care.[16] In the United States, public programs like Medicare and Medicaid were established outside the competitive marketplace in order to

---

13 Health Care Study Group 1994.
14 Health Care Study Group 1994.
15 Even in the US, 42 cents in every HC dollar is financed by government, Borren P and Maynard A. *Searching for the Holy Grail in the Antipodes: the market reform of the New Zealand health care system* England: University of York, Centre for Health Economics., 1993, p15.
16 Donaldson and Gerard, *Economics of Health Care financing*, The Visible Hand, MacMillan Press Ltd, Hong Kong, 1993,p26.

There is now much discussion about introducing more competition into both programs, however, such proposals have engendered a tremendous amount of opposition because it is contended that the introduction of more competition will jeopardise the principles that formed the basis of these programs in the first place.[17] Adam Wagstaff and Eddy van Doorslaer found that;

> 'There appears to be broad agreement...among policy-makers in at least eight of the nine European countries...that payments towards health care should be related to ability to pay rather than to use of medical facilities. Policy makers in all nine European countries also appear committed to the notion that all citizens should have access to health care. In many countries this is taken further, it being made clear that access to and receipt of health care should depend on need, rather than on ability to pay.' [18]

Donaldson and Gerard argue that although no market works perfectly, leaving the resource allocation process to be determined by market forces remains the best way of getting as close as possible to the ideal outcomes of the perfect market.[19] The basic reasoning underlying extensive government intervention in health care, however, is that none of the assumptions of ideal markets work in a health care system. Blank warns that if universal access and cost containment are central to New Zealand health policy and this country moves towards a more market competition among providers, a continuation of government control of the framework for funding and provision of services is necessary.[20]

The failings of market assumptions are manifested in a number of ways, for example in relation to individuals, illness is unpredictable. It follows from this that one cannot plan one's future consumption of health care in the way that one could for other commodities. Such a possibility could result in an expansion of insurance mechanisms whereby an individual or family could make payments to some risk-pooling agency (usually an insurance company) for some form of financial reimbursement in the event of an illness leading to the insured person incurring health care expenses. People who take out insurance are risk-adverse and gain utility form covering the uncertainty of large financial losses.[21] From the foregoing, it would be plausible to say that insurance is a sensible institutional response to the problem of uncertainty in the incidence of large health care expenses.

However, relatively few people, beyond some libertarian and right-wing politicians, believe that all matters pertaining to the delivery of medical care services should be left to the marketplace. Some individuals may believe that health care is no different from any other

---

17 Rice 'Can Markets Give Us the Health System We Want?',1997,p399.
18 Wagstaff, A. and van Doorslaer. E, 'Equity in the Finance of Health Care: Some International Comparisons', *Journal of Health Economics*, Vol.11, 1992, Pp361-387.
19 Donadson and Gerard, *Economics of Health Care financing*, 1993,p26.
20 R.H. Blank, *New Zealand Health Policy: a comparative study*, Auckland: Oxford University Press 1994, Pp119-120.
21 Borren & Maynard, *Searching for the Holy Grail in the Antipodes: the market reform of the New Zealand health care system*,1993, p15.

commodity, but that view is shared by few analysts and citizens. Most market advocates, such as health economists Alain Enthoven and Mark Pauly, support major interventions by the government to subsidise insurance coverage and promote improved rules of the game for an otherwise inefficient market.[22] This is critical considering that insurance markets are haunted by three areas of failure: diseconomies of small scale, moral hazard, and adverse selection. These are examined below.

Diseconomies of Small Scale

Diseconomies of small scale arise in markets with several competing insurance companies, each with its own administrative and marketing costs. In a large company, such administrative costs would be reduced because they would be spread over more customers. However, a large monopoly insurer may be exploitative. An alternative policy response would then be to have a public monopoly so that low costs are maintained without the risk of exploitation. Some costs, such as marketing, checking for eligibility, rebates and premium collection, may be drastically reduced or cut out altogether (for example, premium collection may be 'piggy-backed' onto the taxation collection system.) Diseconomies of small scale result in market failure because it is conceivable that a person would not be willing to pay for insurance which is inflated by the cost of small-scale competition or by an exploitative monopolist, but would be willing to vote for a system involving the collection of premiums through some public mechanism such as taxation.[23] One of the reasons why market mechanisms are often thought to be better than government intervention is that neo-classical theory assumes that such costs are zero, or at least very small. The cost of producing the information to make the market work is ignored. Torrens estimates that the cost of administering private schemes for individual subscribers is more than twice that of the public programme Medicaid which hovers at around 8-12 percent.[24] A significant proportion (20-30 percent) of subscription income in private schemes goes on advertising, sales and administrative expenses adding substantial costs to the provision of health care. [25]

Moral Hazard

The second failing, moral hazard, can be divided into 'consumer moral hazard' and 'provider moral hazard'. Each has two aspects. Consumer moral hazard arises on the one hand because the very fact of being insured reduces the financial costs of treatment at the point of consumption and hence makes being ill less of a liability. Consequently, the incentive to adopt

---

22 A.C.Enthoven, *The History and Principles of Managed Competition*, 1991, Pp.24-48.
23 Enthoven, *The History and Principles of Managed Competition*, 1991.
24 Paton.C, "Health care financing: mobilizing the money" *Health Policy and Management: The Healthcare Agenda in a British Policical Context*, Chapman & Hall, London, 1996.
25 Paton,'Health care financing: mobilizing the money',1996.

healthier lifestyles is diminished and the probability of requiring care rises. Moral hazard is likely to be more significant in certain other spheres (for example, automobile insurance) but it also applies to health. The other aspect of consumer moral hazard is the effect of being insured when sickness occurs and services are required. A zero or reduced price at the point of use encourages a higher rate of use than would otherwise be considered efficient. There is a detachment created between the actual cost the care needed and the value derived by consumers. Thus, the market fails to transmit efficient price signals to consumers.[26] Consumer moral hazard is the form in which moral hazard is most often referred to. The phenomenon can also be explained diagrammatically in figure1.

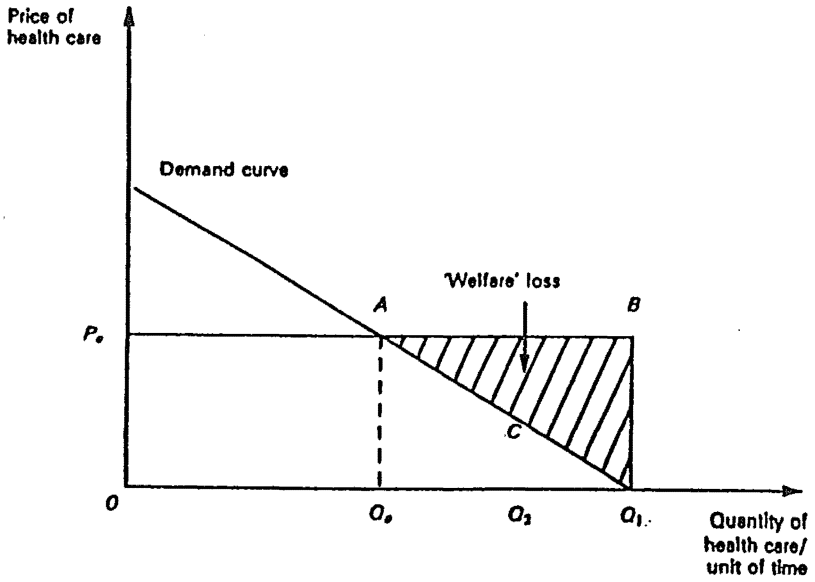

Figure 1 Effect of insurance on demand for health care
Source: Donaldson and Gerard, Economics of health care Financing

In figure 1 it can be seen that a zero price of health care at the point of delivery would result in the over consumption of health care relative to what would occur under normal market mechanisms. At a prevailing market price of *Pe*, the amount of over consumption is represented by the amount *OQ1 - Oqe*. This over consumption results in a welfare loss to society represented by the area *ABQ1* as a result of the benefits to patients of health care

---

[26] Paton,'Health care financing: mobilizing the money',1996.

consumed at *Q2* is represented by the distance between *Q2* and point *C*, while the cost of such care is represented at *P*. More benefit (or welfare) to society could be obtained by shifting the resources expended by these excess demands out of the activities covered by health insurance and either into some other health-inducing activity, or even out of health care altogether. It should be noted that the described model of moral hazard is neo-classical. In particular, the implication is that the individual represented in the demand curve in figure 1 is that of a fully informed and rational consumer. However, this assumption has already been questioned.

Provider moral hazard can result from a simple lack of awareness of costs or from the use of fee-for-service (FFS) remuneration methods for doctors whereby fees depart from 'market prices'. In systems that use FFS methods of remuneration, doctors are paid a fee for items of service provided to patients. For example, a surgeon may receive a fee for a particular operation carried out, a radiologist for reading a mammogram, and a general practitioner for a consultation or for providing a more specific item of service like a vaccination.[27] The danger in such systems is that doctors have a financial incentive to provide care in excess of that which would be given if treating fully informed consumers. The important point is that in FFS systems the potential for unnecessary care only arises when fees depart from the 'true competitive prices' which the doctor would usually receive. Thus, if the fee is greater than the true competitive price there will be an incentive to over provide. Conversely, if the fee is below the true competitive price, then there will be an incentive to scrimp on care.[28]

These dangers cannot be tempered by consumers because, firstly, they often do not have the knowledge to be able to judge what is appropriate and what is not, and, secondly, they have no financial incentive to moderate such behaviour because a third party will be paying for the costs of care. It is commonly found in the United States that a further 'wedge' is driven between the cost of providing care and the value derived by consumers because it is often the employer who negotiates and pays insurance premiums. Thus, there are two 'third parties' whom health care consumers and providers can pass costs onto - insurance companies and employers. The consequence of moral hazard (of all kinds) has been rising premiums which are ultimately borne by the consumers themselves. Similarly, in publicly-orientated systems, such as the UK and Scandinavia, health care providers do not incur the full opportunity cost of provision in many aspects of care (for example diagnostic tests), therefore, rendering them prone to provider moral hazard arising from a lack of awareness of costs.[29]

Moral hazard also exists in private insurance-based health care systems. With a third party (i.e. the insurance company) paying health care bills on a full reimbursement basis and employers contributing heavily to premiums, neither the consumer nor the provider has an incentive to be cost-conscious. The consumer faced with free or low cost health care at the

---

[27] Paton,'Health care financing: mobilizing the money',1996,p.32.
[28] Paton,'Health care financing: mobilizing the money',1996,p.32.
[29] Paton,'Health care financing: mobilizing the money',1996,p.36

point of consumption has little or no financial incentive to restrain demands on the service. Likewise, doctors have no financial incentive to moderate such demands. Indeed if reward is on a fee for service basis, as is often the case, they may have an incentive to generate demand for their services (the phenomenon of supplier-induced demand). Even today, in parts of the hospital sector in the USA, moral hazard is further exacerbated by the existence of retrospective cost reimbursement of hospitals by insurance companies. Such practices discourages monetary responsibility.[30]

To combat the problem of moral hazard, cost-sharing or co-payment schemes have been introduced by insurance companies. Essentially, the aim of these schemes is to place some financial burden on the consumer to eliminate or at lease reduce 'unnecessary' use of health care. Individual schemes differ according to the nature of the financial arrangement but take four main forms, a flat rate charge for each unit of service, co-insurance (the insur[illegible] has to pay a certain proportion of each unit of health care consumed), a deductibl[illegible] 'excess' in some motor vehicle insurance policies (the individual pays 100 per cent of all bills in a given period up to some maximum amount beyond which insurance benefits are paid in full), or a combination of the last two.[31]

Adverse selection

Adverse selection results from an imbalance of information in the insurance market; that is, buyers of insurance often have more of an idea of their risk status than sellers of health care insurance. Initially, in a competitive market if the insurance companies have no idea of individual risk status, a premium could be set reflecting the general health risk of the insured population. Thus, the premium paid by everyone who takes out insurance would be the same, reflecting the 'average' risk level of the insured population. This is what is called 'community rating'. For some members of the insured population who perceive their own risk level to be lower than average, this community rating premium will seem to them to be too high. Moreover, such low risk groups are usually younger and do not feel that health care is a necessary cost. They will, therefore, elect not to take out health care insurance and will not be covered in the event that the unexpected happens. More importantly, however, the effect of this decision is that the average risk level of those remaining insured will rise because it is people of lower-than-average risk who have dropped out of insurance. Thus, to cover the projected health care costs of this population, premiums must rise. Once again, the result of this is that those perceiving their risk status to be lower than the average of those remaining insured will drop out of insurance, and the process will carry on. This process, whereby the best risks are selected out of the insured group, is called 'adverse selection'.[32]

---

30 Paton,'Health care financing: mobilizing the money',1996p.56
31 Paton,'Health care financing: mobilizing the money',1996,p.56
32 Paton,'Health care financing: mobilizing the money',1996, p.33.

drop out of insurance, and the process will carry on. This process, whereby the best risks are selected out of the insured group, is called 'adverse selection'.[32]

In a competitive system other phenomena would be expected to follow from adverse selection. The presence of a low-risk, uninsured group of people presents the opportunity for insurance companies to tailor premiums to levels of individual risk, rather than population risk. This is 'experience rating'. If fine distinctions can be made, a premium will reflect assumed future risk level based perhaps on some idea of past history of personal and family health as a predictor for the future. As a result of this process, higher-risk groups (typically the lower-paid, elderly people and the chronically sick) will be required to pay higher experience-related premiums to maintain coverage, premiums which they may not now be able to afford. The process by which low-risk individuals are drawn into low-premium plans is often referred to as 'skimming' or 'creaming off'.[33]

How then does adverse selection constitute market failure? Two groups of people may be left uninsured as a result of adverse selection, those of low risk who start off the cycle by pulling out of insurance at community rates and those in high-risk groups who cannot afford experience-rated premiums. Adverse selection constitutes market failure for the former group because both insurer and customer are willing to enter into a contract, but the necessary information required for the transaction is not transmitted from one party to the other via the market. The transaction is prevented by asymmetry of information about risk status. Low-premium insurance policies could be offered, but because of asymmetry, insurance companies would have no prior information on potential customers which would not help them to determine whether inappropriate high risk individuals are applying. Therefore, the policies are not offered. Despite this failure of the market, society may not wish to respond because the failure mainly affects a group which are not big users of health care and are not so affected by the failure. For the high-risk group, adverse selection creates market failure as it is a direct catalyst for premium rises. Premiums are increased to the point where they are beyond the budget of people who are in the high risk group. The elderly, the sick and the beneficiaries are consequently priced out of the market.[34]

Primary Health Care Financing Models

This next section provides a synopsis of four health care financing models. The first is a mix of both public and private financing and is the most predominant structure amongst OECD countries. The second is the private health care insurance model which includes both the preferred provider organisation (PPO) and the Health Maintenance Organisations (HMOs)

---

[32] Paton,'Health care financing: mobilizing the money',1996, p.33.
[33] Donaldson and Gerard, *Economics of Health Care financing*, 1993, p.36.
[34] Donaldson and Gerard, *Economics of Health Care financing*, 1993, p.37.

countries have implemented. Most OECD countries use some variation of these models in order to provide health care financing (detail of the exact types are specified in Chapter 2).

1.Mix of Public & Private Financing

According to Cowan (1990), one of the most important lessons of the past decade has been that privatisation is just one instrument among many that must be employed if economic recovery is to be achieved. The responsibility for greater efficiency and higher production must be shared by both the private and the public sectors. The problem is how best to mix these sectors so that the welfare of both the individual and society can be most effectively advanced. Once privatisation begins it cannot be easily reversed. If it succeeds, a popular constituency for it is created.[35] The organisation of financial intermediaries may be on a monopolistic, oligopolistic or competitive basis. In a monopolistic system, the financial intermediary is usually a public agency such as a government, a quango or a health corporation. In an oligopolistic system (i.e one in which there are a small number of large intermediaries) finance can be controlled by public agencies or private agencies, such as insurance companies, or a combination of these. In a competitive system, a large number of small private intermediaries would exist. The closest practical example of this latter system is one based on the vertically-integrated Health Maintenance Organisation (HMO) which provides a package of primary and tertiary care in return for a prepaid premium.[36]

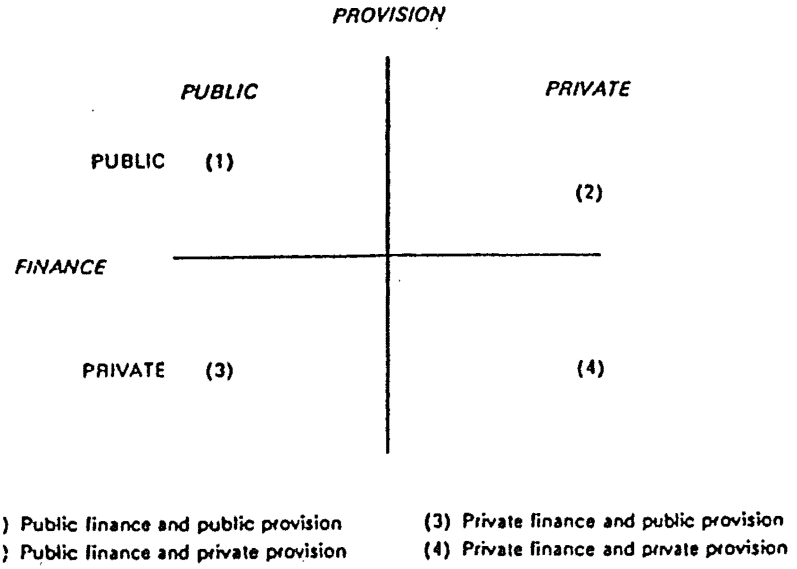

Figure. 2 Public/private mix in health care financing and provision

Source: Donaldson and Gerard, Economics of health care financing, 1993

---

[35] G.L Cowan, *Privatization in the developing world*, Praeger Publishers, New York,1990, p.6.

[36] Cowan, *Privatization in the developing world*,1990,p.53.

The provision of services, however, does not necessarily have to match the financial organisation. For instance, hospital care in many European countries represents a large, vertically integrated health system in which finance and provision are combined within one organisation. Both finance and provision are public as in the case of quadrant (1) in figure 3. In many countries, general practice would fall into quadrant (2) where such care is provided by self-employed doctors who, nevertheless, happen to receive almost all of their income form the public purse. A system based on HMOs, on the other hand, represents a similarly integrated (but privately funded) system which could fit into quadrants (3) and (4), when purchasing care from private or public providers.

Donaldson and Gerard contend that it is important to recognise that systems do not have to be vertically integrated in these ways.[37] A third party private payer, such as an insurance company, could also fit into segments (3) and (4). The fundamental point is that public finance does not have to match public provision, nor does private finance have to match private provision. Public provision could be financed by private arrangements (private insurance, direct charges, etc.) and private provision by public finance (e.g. prospective payments made by government agencies directly to private hospitals).[38] Control of financial arrangements gives governmental bodies more direction over the health care system in the pursuit of societal objectives. The Government's role is seen as financing rather then in providing health care. As the collective purchaser of care on the community's behalf, a public body can dictate terms of provision with equal power to both public and private providers.[39] Simply providing public services does not guarantee use by those groups for whom they are intended, because healthier, richer or privately insured patients may be more 'attractive customers' for hospitals than those more in need of care. New Zealand's public sector finances 77 percent of health care while 6 percent is financed through private insurance, and the other 17 percent financed by out of pocket private payments. Hence, the mix of financing for health care represents three quarters public one quarter private.[40]

---

37 Cowan, *Privatization in the developing world*,1990,p.53.

38 Cowan, *Privatization in the developing world*,1990,p.53.

39 R.G Evans, 'Public health insurance: the collective purchase of individual care', Health policy 7, 1987, Pp.115 - 134.

40 The state picks up nearly the same percentage of the costs of the health system as it did in the 1970s. Concern over the condition of New Zealand's pulic health system has led to increasing numbers of New Zealanders deciding to take out some level of health insurance. But while the number of New Zealanders with health insurance is climbing towards 50 percent, the percentage of total health costs funded by private individuals, either directly or through health insurance, has changed little since the 1970s. as cited in *The Evening Post*, 'Insurance picks up the tab',_24 Sep. 1996, p6.

2. Private Health Care Insurance

Globally, governments have proven to be quite tough as budgetary negotiators and are imposing increasingly stringent controls on health care expenditures as their own fiscal position weakens. Private insurers, on the other hand, have no particular incentive to limit cost escalation, if anything it is to the contrary. From the point of view of providers, the optimal situation, at least in economic terms, is to have complete freedom to set prices and choose treatment patterns, but to have a high level of insurance coverage in the population so that the resulting bills will be paid.[41] American experience indicates that a high level of coverage requires very large public subsidies, directly for the elderly and poor, and through tax expenditures for those with private coverage. But the tax expenditure subsidies for private insurance can, as shown in the United States, be structured to yield the greatest people in higher income brackets.[42] The expansion of private insurance within a public system of health care finance offers benefits to both providers (higher prices) and upper-income payers (a more regressive financing structure). It therefore supports a potent political alliance. Additionally, if providers are able (selectively) to recruit people into the private insurance system by offering them the reality, or even just the possibility, of superior services, this reinforces the financial advantages. However, the complex administrative mechanisms for achieving these redistribution objectives are themselves costly. They result not only in higher incomes for (some) providers, but in an increasing flow of resources into the overhead costs of managing the health care system.

The inherent instability of private health care financing also leads to uncontrolled cost escalation. This, in turn, generates an administrative arms race as each payer struggles to shift the ever-increasing cost onto others. Such efforts are highly rational, indeed necessary for survival, at the level of the individual institution. From the perspective of society as a whole, they generate an ever-increasing level of pure waste motion.[43] The uncertainty surrounding the incidence of ill-health and the efficiency of treatment means that health care is seen as an

---

41 R.G Evans, 'Public health insurance: the collective purchase of individual care', 1987, Pp.450-451.
42 R.G Evans, 'Public health insurance: the collective purchase of individual care', 1987,Pp.451-452
43 Some have challenged the identification of excessive adminnistrative costs with waste in K.E.Thorpe, 'Inside the Black Box of Administrative Costs'. Health Affairs, 1992,p.11. They point to the extraordinnarily sophisticated management techniques in the United States, the extent and detail of data generated, and the leading-edge research in health services. In these, the United States celary does lead the world. But as Evans contends such responses, however, miss the point. Managerial (and even reserach) activities are not ends in themselves. They are only valuable issofar as they contribute to the ultimate ends of a more efficient and effective HC system, and a healthier and more satisfied population. As the United States achieves much worse results than systems that spend much less, extra administrative expenditure is wasted, regardless of how much sophisticated management it may buy. It apears to support a vast negative-sum game of interinstitutional competition over cost transfer and benefit appropriation.

appropriate case for insurance. Insurance can help individuals and groups to adjust in preferred ways to these uncertainties. As has been seen, this may be achieved by government intervention providing comprehensive public insurance, by a combination of government and private finance or by a comprehensive range of private finance. For a given premium a set of health care risks may be insured against. In the case of pure private insurance, the insurance company covers specified risks of ill-health to the consumer and incurs the consequential expense of health care. Private insurance companies usually operate in a market with a small number of large companies (an oligopolistic structure). Although such a structure may achieve economies of scale, there is an incentive for companies to act together to strengthen their power in the market and in doing so keep premiums high and in line with each other.[44]

New Zealand has two main health insurance providers, Southern Cross health care which has a market share of about 60 percent, and Aetna health care which has about 19 percent of the New Zealand's health insurance, covering some 240,000 people. Other smaller companies, such as National Insurance Life, covers approximately 5 percent of the market. Health care packages vary with the amount of cover and cost, but prices between companies with comparable packages are similar. Aetna New Zealand has increased premiums in 1996 by an average of 20 percent. These increases follow similar rises by the country's largest insurer Southern Cross.[45]

Depending on the level of charges for health care, people in low-income groups or high-utilisation groups may be excluded from consumption as a result of a lack of ability to pay. Government intervention may be required in such a situation. There is also likely to be some anxiety about the effect on an individual's health if they are deterred from 'non-trivial' utilisation. Cost sharing need not, however, reduce the overall impact of supplier-induced demand. Doctors may, for example, switch their demand-inducing abilities from lower-income groups to those more able to pay. With the presence of supplier-induced demand, cost containment does not seem so obviously achievable through cost sharing. Even worse, serious health problems may be left untreated as more minor (but able-to-pay) cases replace more serious (not-able-to-pay) cases. Potentially the same amount could be spent on health care but to less effect in terms of improvement or maintenance of the community's health.[46] Consumers in a private insurance system are given a central role in choosing the nature and extent of their own health care coverage. They are able to purchase additional health care insurance according to their own preference and, of course, ability to pay. The provision of high-quality care and other peripheral services is typically greater than in governmental systems.[47]

---

44 K.E.Thorpe, 'Inside the Black Box of Administrative Costs',*Health Affairs*, 1992,p.11.
45 Bailey. G, 'Aetna insurance for elderly $2000 a year' *The Evening Post*, 11 Sep 1996,p.56
46 Bailey. G, 'Aetna insurance for elderly $2000 a year' *The Evening Post*, 11 Sep 1996,p.56
47 Bailey. G, 'Aetna insurance for elderly $2000 a year' *The Evening Post*, 1996,p.57

'If you're poor in New Zealand you're twice as likely to die in any given year as someone who is well-off'.[48] Ichiro Kawachi, an assistant professor in the school of public health at Harvard Medical School in Boston, believes that this applies to New Zealand. Kawachi states that since the introduction of Rogernomics, ill-health among the poor has increased, particularly for Maori. While Western nations generally have an improving life-expectancy, New Zealand's rate of improvement is contrary to that trend. The under-privileged are the most affected and this group is growing rapidly. Kawachi claims that while the rich are getting richer, a rapidly-growing under class is trapped in a poverty cycle with a rapidly falling life expectancy. That decline is dragging New Zealand's international life expectancy ranking down. This is blamed on the monetarist policies of the Fourth Labour Government which have been continued by National. Health Ministry briefing papers for the incoming Government show that in the last 30 years New Zealand men have slipped from having the seventh-highest life expectancy rate to 13th amongst 25 OECD countries. Women's rates over the same period have fallen from 10th to 17th.[49] These trends show that while there may be uncertainty surrounding the incidence of ill-health, only certain groups in society have the ability to take out the insurance cover necessary to protect themselves. The others (without an ability to pay) are reliant on government provision. While consumers in a private insurance system are theoretically given a central role in choosing the nature and extent of their own health care coverage, realistically many are denied this choice as their soci-economic status has already determined it for them, hence the health insurance system fails them.

i) Preferred Provider Organisation

One recent major reform in private health care insurance markets in the USA has led to the growth of Preferred Provider Organisations (PPOs). They arrange contracts with medical professionals to carry out specific operations, procedures or other medical duties at a set rate. This keeps costs down for the insurance companies and allows them to budget more accurately. PPOs have arisen in the USA as a result of attempts by insurance companies to enter into competition with HMOs. Premiums are either paid by employers or are shared between employer and employee. Price at the point of use of services is zero. Insurers contract selectively with providers (e.g. primary care doctors and hospitals who provide care below a cost per case). The contract is on the basis of both a negotiated fee schedule, which the preferred providers accept as payment in full and acceptance of utilisation review. User charges and deductibles tend to be lower in PPOs than under previous private insurance arrangements.[50]

---

48 J. Saunders, 'The nation with a heart of stone', *The Evening Standard*, 8 Febuary 1997.
49 Saunders, 'The nation with a heart of stone',1997.
50 J. Zwanziger and R.R Auerbach, 'Evaluating PPO performance using prior expenditure data', Medical Care, 29, 1991, p142-151.

Donaldson and Gerard claim that adverse selection and experience rating will almost inevitably develop within a care system based on PPOs, leaving the more costly groups without health care cover unless they are subsidised.[51] There is also no financial risk to primary care providers with respect to the volume of services provided. With FFS as the basis for payment the doctor can, to some extent, manipulate utilisation. However, this has a limit, because if cost per case rises above a certain limit, then the sector may not be selected as the preferred provider at the next review. The incentive for hospitals to keep costs down arises because a set of prices has been agreed in advance.[52]

Patients can choose between a limited set of providers or choose another provider on less favourable terms, so incentives also exist on the demand side. One specific advantage of PPOs is that they have enabled employers in the USA to move quickly to control health care costs for employees who are already under FFS schemes. Companies either organise schemes themselves or persuade insurance companies to do it. Insurance companies co-operate because this provides a means of competing with HMOs.[53]

ii)Health Maintenance Organisations (HMOs)

Health maintenance organisations (HMOs) are a product of private insurance systems. HMOs provide (or arrange and pay for) comprehensive health care for a fixed, periodic per-capita payment (or 'premium') which is paid for by the consumer (usually with a subsidy from employers or social security). Consumers do not usually pay charges at that point. The premium is set in advance and is independent from the volume of services provided to the individual during the period. Providers can be salaried or paid by FFS. Adverse selection and experience rating will inevitably arise if, as is likely, competition develops. Doctor demand inducement is unlikely to be very prevalent because not only do doctors compete for custom, usually on an annual basis, but also the annual HMO budget is fixed in advance. Because any discrepancy between the budget and expenditure will fall on the HMO and thereby to the doctors, there is a much greater incentive for doctors to be cost conscious. High spending doctors will then be financially penalised.[54]

Organisationally, HMOs can be of one of four types: a staff model, in which all doctors are employed and/or contracted directly by the HMO, a group model, in which the HMO contracts with an independent group practice to provide services, a network model, in which more than one independent group is contracted to provide services, or an independent practice association (IPA), in which the HMO contracts several doctors in independent practice. Consequently, there are many financial and organisational variations on the basic

---

51 Donaldson and Gerard, *Economics of Health Care financing*, 1993,p58.
52 Donaldson and Gerard, *Economics of Health Care financing*, 1993,p59
53 Donaldson and Gerard, *Economics of Health Care financing*, 1993,Pp.60-61
54 Donaldson and Gerard, *Economics of Health Care financing*, 1993,p.63

HMO model. Consumers select the health care plan of their choice on an annual basis, therefore, more choice is thought to exist. Because consumers usually receive only a fixed subsidy towards payment (or a fixed percentage of the premium), they too have an incentive to be cost-conscious. Additionally, some HMOs do have user chargers, particularly for drugs.[55]

3. Direct Tax System

A system of direct taxation removes the problem of adverse selection because of the absence of competition between financial intermediaries.[56] By detaching premiums from expected risk levels and making them compulsory, a tax system redistributes wealth from those with low *ex ante* expectations of illness to those at high risk. Individuals are effectively charged one form of community rate, one which is dependent on an ability to pay, but not on previous experience of ill-health. A tax-financed system redistributes according to two indicators of individual well-being, health status and income. It can, therefore, be more efficient than any form of redistribution based on income alone, although there is no guarantee that it will be. It also provides the means of effectively capping total expenditure, provided that there is the political will to contain expenditure. Such a system is virtually free form 'loading' problems, representing probably the most efficient way of collecting Moines to finance the health care system (often referred to as 'piggy-backing' onto the existing system of tax collection). The use of nominal charges may be seen to provide an incentive to the consumer to restrain some demand, particularly so-called 'unnecessary' ('frivolous' or 'trivial') demand.[57] Within the public sector, however, there is no systematic financial signalling system of the sort a well-ordered market would provide. This would inform participants about intersectional costs, such as GP versus hospital outpatient care, and internal costs which could form the basis of clinical budgets or prepayments per case. Thus, in NHS-type systems, decisions about the optimal balance of services usually have to be made either in the face of considerable ignorance about likely cost and likely benefit or only after in depth study. The system does not generate a pricing mechanism for routine 'managerial' choices. Nor does it provide a continuing environment of penalties or rewards for inefficient or efficient behaviour. Those who commit resources (the doctors) usually do so in ignorance both of the financial cost of each clinical decision and of the true opportunity cost in terms of the health services that have not been provided to others. The budgeting systems that constrain doctors are also typically constructed in extreme ignorance about both costs and benefits. This ignorance can simultaneously lead to claims by some that the total health service financial resources are not used effectively, while others claim that the service is under funded. The difficulty lies in the

---

55 B.L Harris, A.Stergachis and D.L. Reid:'The effect of drug copayments on utilisation and cost of pharmaceuticals in a health maintenance organisatin', *Medical care*, 1990, p908.
56 Refer table.1, thrid coloum under direct taxation.
57 Donaldson and Gerard, *Economics of Health Care financing*, 1993, p.59

fact that it is impossible to decisively refute or support either of these claims, at least, not with current levels of knowledge about costs and benefits.[58]

4. Public Health Care Insurance

A public insurance system can be administered by a monopolistic agent, such as a quango (semi-autonomous, non-governmental organisation), a regional government, or a national government. For purposes of equity, premiums can either be indexed to income or, as is possible with private insurance, be made tax-deductible. Premiums can be deducted directly through payment by the employers of low-paid workers. The resulting fall in demand for the less skilled leads to still lower wages and/or more unemployment. Moreover, arrangements would have to be made to ensure cover for the unemployed (voluntary or involuntary), the retired, those not in the labour force, and the dependants of those individuals.[59]

Care would normally be provided free at the point of use of services under public health care insurance, although it would be possible to introduce co-payments and charges for 'hotel' services. General practitioners could be paid on the basis of salary, capitation or fee for service (or some combination). There is the possibility of tight government control over fee schedules. Hospitals could be reimbursed in a variety of ways: retrospectively, prospectively, by size of the population served, item by item, globally, with or without peer review and with or without monitoring of outcome and the quality of care. Some hospital income may also come from FFS, nominal charges to patients, and for charges for 'hotel' and other on-site and peripheral services.[60]

The crucial aspect of a public health insurance system is monopoly of finance. The lack of competition between financial intermediaries prevents adverse selection and experience rating. There may also be economies of scale and the avoidance of the recording, billing, collection and enforcement costs (e.g. checking for fraud) of private insurance systems. Competition can take place in a public health care insurance system, for it is possible to envisage the presence of both public and private service providers where the private sector is subject to the same system of payment as the public sector (e.g. internal markets). Advantages may be gained from competition among providers of care because the public insurance agency (in Canada, the provincial government) acts as the collective purchaser of services on the community's behalf.[61]

It is from these four models that OECD countries have structured the financing of there health care systems. Table 1 characterises the main options for raising finance. Within each, of these new systems some principal variants are recognised which control moral hazard

---

58 Donaldson and Gerard, *Economics of Health Care financing*, 1993, p.62
59 Donaldson and Gerard, *Economics of Health Care financing*, 1993p.62
60 Donaldson and Gerard, *Economics of Health Care financing*, 1993, p.62.
61 Evans, 'Public Health Insurance; the collective purchase of individual care', p.118.

by consumers, doctors and institutions, and deal with adverse selection. HMOs are aimed at controlling both consumer and provider moral hazard. Other methods, such as charges, can be used in all types of system. The options under public insurance and direct taxation systems are identical except that public insurance systems can include compulsory community-rated premiums plus an experience-related subsidy.[62]

	Basic system for raising finance		
	Private insurance	*Public insurance*	*Direct taxation*
Controlling consumer moral hazard	Charges HMOs PPOs Fixed indemnity (i.e. cover for approved packages only)	Charges Non-price rationing	Charges Non-price rationing
Controlling provider moral hazard	Doctors: Fee for service Capitation Salary Competition (through HMOs etc.)	Doctors: Fee for service Capitation Salary Payments for good practice Budgets	Doctors: Fee for service Capitation Salary Payments for good practice Budgets
	Hospitals: Retrospective budgets Prospective budgets Payment by case (DRG) Payment by day Competition (through HMOs etc.)	Hospitals: Retrospective budgets Prospective budgets Payment by day Internal markets	Hospitals: Retrospective budgets Prospective budgets Payment by day Internal markets
Controlling adverse selection	Compulsory community-rated insurance plus experience-rated subsidy Vouchers Charges plus catastrophic insurance Special schemes for poor, elderly and disabled people	Integral part of the system (100% coverage of population) Can involve compulsory community-rated insurance plus an experience-rated subsidy	Integral part of system (100% coverage of population)

Table 1 Options arising from funding arrangements for health services: controlling moral hazard and adverse selection

Source: Donaldson and Gerard, Economics of health care financing

In Table.1 column one *Private insurance* shows the combination of mechanisms which can be used to control moral hazard and adverse selection. At the bottom of this column on controlling adverse selection it may be seen that the basic system for raising finance notes the implementation of 'Special schemes for poor, elderly and disabled people.' As the column *Public insurance* demonstrates there is provision for an experienced-rated subsidy. Under this the elderly would be entitled to a subsidy which pays part of there insurance premium. Currently in New Zealand there is no such subsidy for the elderly.

---

62 Donaldson and Gerard, *Economics of Health Care financing*, 1993,p.64.

New Zealand's system combines a mix of both public and private financing with rapidly increasing levels of private involvement matched with a steady public decline. Of particular interest here is the private health care insurance model, for as New Zealand withdraws from public provision, greater reliance is bearing on private health care insurance to provided essential medical care to New Zealanders.

Conclusions

In spite of the fact that most questions in health policy can be answered only through empirical research, an examination of the theory is important to understanding the direction of the government and their expectations when developing health care policies. Rice contends that if analysts misinterpret economic theory as applied to health by assuming that market forces are necessarily superior to alternative polices, then they will blind themselves to policy options that, although falling outside the conventional, demand-driven competitive model, might actually be better at enhancing social welfare.[63] Market forces do have a prominent place in health care organisation and delivery, but, as has been shown, economic theory has a number of strong critics who address essential shortcomings. Many of these are exacerbated when applied to health care. The most prevalent shortcomings are, first, market mechanisms which yield distribution advantages for particular influential groups, such as the wealthy and the business world. Second, inelastic demand for health care means that if prices increase demand will remain the same, creating an environment ripe for exploitation by profit making companies. Third, the likelihood of cost escalation is due to the diminished incentive to contain costs. Fourth, a lack of knowledge in the market place which creates an imbalance of information when increased information which is one of the main justifications for market involvement.[64] Fifth, the fundamental problem of the market system's inability to provide equity of access.

As New Zealand's health care system is now relying increasingly on private health insurance companies to provide care, the theory of insurance market failure is useful to gauge problems likely to arise. Part two will assess each one in turn with the empirical research gathered from the interviews and case study. The various types of health care financing systems that are used by the OECD countries has been outlined to reveal the alternative options available to the planners of New Zealand's health care system.

---

[63] Rice, 'Can Markets Give Us the Health System We Want?',1997,p.422.
[64] R.Scollay, S. St John, 'From micro to macroeconomics' *Macroeconomics and the contemporary new Zealand Economy*, Addison Wesley Longman New Zealand Limited, 1996, p9.

CHAPTER TWO

International Trends & Lessons in Health Care Provision

Virtually all OECD countries face the same problems and have common objectives concerning health care, particularly the provision of quality health care at an affordable cost. They have all experienced sluggish economic growth over the past 13 years compared with the first three decades following the Second World War. They all have ageing populations. They all confront the problem of potential costs arising from the continuing development of health technologies and a large percentage of them are increasing their levels of private funding into health care while reducing the public amount.[1] Part of this chapter will study the impetus for these changes, the purpose being to understand where the drive for reform is sourced and to illuminate international trends in areas relating to the dynamics of demographic transition. Also an analysis of the various financing models of health care, health expenditure and the role of the private sector in other countries is made. New Zealand's position regarding 'the international standards' of financing health care is assessed in an attempt to determine the extent of New Zealands' conformity or conversely its divergence from these. Furthermore, consideration is given to the first postulation, that the governments shift from a 'social equity model' in health care provision to one based on 'competitive markets' has created an issue with distribution, which favours certain minority groups and disadvantages others, namely the most rapidly growing in New Zealand - the elderly. It is to the central element concerning distribution and the minority group which is favoured that will be focused on here.

Elderly and Growing

Population ageing is not a phenomenon unique to New Zealand. Growth in elderly populations is one consequence of a phenomenon first recognised in European societies known as the "demographic transition". This process is common to most developed industrialised nations.[2] From the individuals point of view most would agree living longer is desirable. To the state, however, it means developing policies to deal with the future costs of this expanding group and their demands on limited resources such as health care.

---

[1] OECD, Health Data, The comparative analysis of 27 Health Systems, 1996.
[2] *New Zealand Now 65 Plus, Statistics New Zealand,* Wellington, New Zealand,1995, p14.

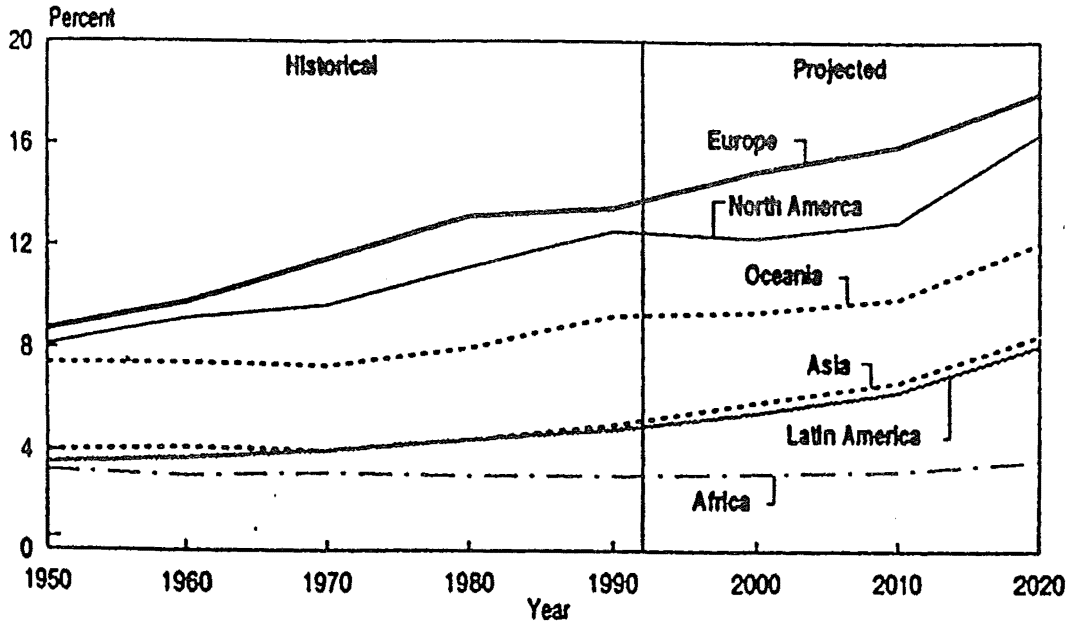

Figure 3. Elderly Population by Geographical Area, 1950-2020

Source: New Zealand Now 65 plus, 1995

Some of the world's oldest population structures are found in European countries (as figure 3 shows) where the demographic transition began much earlier than in New Zealand. European populations have continued to grow progressively older since the end of World War II. In 1950, fewer than 10 percent of Europe's population was aged 65 years and over. By 1990, this had risen to an estimated 13 percent and by the year 2020, it is projected to reach around 18 percent.[3]

New Zealand is experiencing its own demographic transition. Low fertility has led to fewer young people in the population, while declining mortality has led to the increasing size of older age groups in the population structure. Comparing New Zealand's ageing population with that in other countries shows that in 1951, 9 percent of New Zealand's population was aged 65 and over. This was higher than the 1950 levels in countries such as Australia, Canada and the United States, but less than the levels in France, Sweden and the United Kingdom (as shown in figure 4).[4]

---

[3] *New Zealand Now 65 Plus, Statistics New Zealand,* Wellington, New Zealand,1995, p14.
[4] *New Zealand Now 65 Plus, Statistics New Zealand,* Wellington, New Zealand,1995, p14.

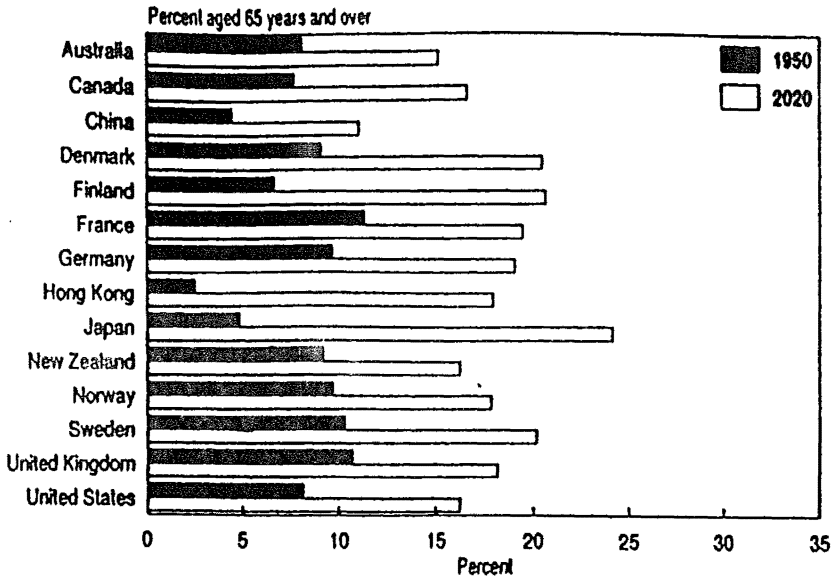

Figure 4. Elderly Population, Selected Countries, 1950 and 2020.

Source: New Zealand Now 65 Plus, 1995

By the year 2021, New Zealand's elderly are expected to make up around 16 percent of the total population. By the middle of next century they are predicted to be one in four which is a similar proportion to Australia. Countries such as Denmark, Finland, Japan, and Sweden which have experienced sub-replacement fertility in the 1970s and 1980s will have more than one in five people in this age group by 2021.[5] The growth in Japan's elderly population during the 1950-2020 period is expected to be spectacular, with the elderly projected to increase from 5 percent to almost 25 percent of Japan's total population.[6] As a result of this, a number of implications for policy development emerge which will cater for the greater diversity of needs within that population. Why is this a concern for those concerned with health care? As Blank[7] purports elderly persons are the leading users of hospital care on a per capita basis and have the highest expenditures for health care in the United States. Ironically, because of medical improvements and technologies that prolong life, chronic disease requiring frequent medical care has become a greater problem. Obviously, the demand for such care will continue to increase in an ageing population. Studies have confirmed that the elderly are high-cost users of medical care, much of which in the United States is funded by the federal government through Medicare and Medicaid. In 1980, for example, 63.9 percent of the health care expenditures for those over 65 years of age was paid for by the public sector. This contrasts with 28.6 percent for those under 65.[8] In New

---

[5] Sub-replacement fertility is when the number of births in a population is below the level needed for the population to reproduce itself.

[6] *New Zealand Now 65 Plus, Statistics New Zealand,* Wellington, New Zealand, 1995, p14.

[7] R.H, Blank Rationing Medicine, Columbia University Press, New York 1988.

[8] Blank, *Rationing Medicine*, 1988.

Zealand those over 60 make up 16 percent of the population and use 44.3 percent of the health budget.[9] This ageing and consumption high group are going to put an increasing strain on the health care system to provide them with both elective and acute health care. This could certainly be suggested as one reason for the implementation of reforms to the health care system, to transfer this future cost from the government onto the elderly directly.

The World Wide Drive for Privatisation

In 1991 the newly elected government embarked on a comprehensive restructuring of the health system. The Green and White Paper of 1991 laid out the foundations for the reform, citing a number of benefits likely to result from the change the proposals included;

- dividing the role of area health boards into services purchase and provision
- separating the organisation and funding of public health from personal health care services
- encouraging competition among providers
- integrating within one agency the funding for all personal health care
- encouraging continuity of care and co-ordinated management across the spectrum of personal health care services
- providing access for everyone to an acceptable level and quality of services while allowing greater freedom of choice for individuals
- exlicitly defining "core health services" for which government funding would be available, although not necessarily fully funded by the state
- retaining the state's role as the major funder of the health sector
- encouraging individual responsibility for health care
- formalising the system of user charges for personal health care services, and
- strengthening and redefining the role of the Ministry of Health as a key policy adviser to and monitoring agent for the government.

These proposals, with amendments, were largely implemented on 1 July 1993 by way of the *Health and Disability Services Act of 1993.*[10]

Plans to reform have required the dismantling of the previous health system so as to create a new system based on 'managed competition'. In this new regime health-service provision is organised through processes of competition among and between private and public funders and providers of health care. The changes being made easily rival those created by the 1938 *Social*

---

[9] *New Zealand Now 65 Plus*,1995,p.21.
[10] OECD, *The Reform of Health Care Systems, A Review of Seventeen OECD Countries*, Paris, 1994,p.237.

Security Act which set the parameters of the previous system. The current health reforms, like those in 1938, are part of a much larger pattern of upheaval and transformation of political, economic and social relations in New Zealand. Politically, this transformation began in a sustained way with the election of a Labour government in 1984, continued with Labour's re-election in 1987 and has been pushed still further, by the election of a National government in 1990.[11]

The move to reform was not isolated to New Zealand alone. Since the 1970s there have been global attempts to restructure the welfare state in capitalist industrial societies, especially those characterised by high rates of public expenditure, large budget deficits, and low rates of economic growth.[12] Recession economies have been used as one of the reasons why governments have cut back social expenditure and adopted alternative means of funding the provision of essential social services. Attacks on, and attempts to restructure the welfare state have, for the most part, been the preserve of the political right which has usually defended its actions on the grounds of questioning both the efficiency and the effectiveness of public expenditure.[13] High rates of social expenditure are seen as having a negative impact upon rates of economic growth and are also said to create social dependence and high levels of taxation which act as disincentives to work and save. It is also argued that many public services are characterised by inefficiency and ineffectiveness.[14] Perhaps nowhere is this more evident than in the health sector where there has been a growing scepticism over the rising cost of medicine, especially in view of its relatively minor impact upon health outcomes in industrial societies.[15]

The New Zealand health reforms, however have to be seen in the context of a world-wide drive for privatisation. The 1990s era of budget cutting and privatisation began at the end of the 1970s with the election of Margaret Thatcher as Prime Minister of the U.K in 1979, and Ronald Reagan as President of the United States in 1980. Both were pledged to the reduction of expenditures for public services and their privatisation, and shifting the tax burden from the very rich to the working and middle classes of the population. As Milton Terris, a leading American public health specialist, has pointed out:

---

11 A. Sharp, , 'The Changing Role of the State in New Zealand since 1984', *A Leap into the Dark*, Auckland University Press, 1994, p107.

12 I.Gough, and A. Steinberg, 1981, The Welfare state, capitalism, and crisis. Political Power and Social Theory 2, Pp.141-171, as cited in J. L.Scarpaci, Health Services Privatisation in Industrial Societies, Rutgers, United States, 1988.

13 Gough & Steinberg, The Welfare state, capitalism and crisis, 1981.

14 New Zealand Department of Health 1988.

15 I.Kawachi, 'The American Connnection', *Health Reforms, A Second Opinion*, 1992.

'These policies have been exported to the rest of the world through the International Monetary Fund [IMF] and the World Bank, which have followed a consistent policy for demanding adherence to so-called 'austerity measures', austerity for the working and middle classes, and prosperity for the rich and powerful, as an essential condition for receiving loans for their hard-pressed economics[16] In the field of health, for example, the World Bank in 1987 published the following entitled, *Financing Health Services in Developing Countries: An Agenda for Reform*, which proposed that 'an agenda for reform in virtually all countries ought to be carefully considered'. It is not surprising then, that no fewer than 18 out of 24 OECD countries were planning or implementing major changes to health services by 1991.[17] The common problem, it was argued, was an ever increasing demand for health services as a result of an ageing population, new technologies and higher consumer expectations. It may be seen as surprising that for some reason the most radical reforms implemented in all of the OECD countries have indeed occurred in New Zealand and Sweden.[18]

The World Bank's agenda for reform included four policies: charge users of government health facilities; provide insurance or other risk coverage;[19] use non-government resources effectively; and decentralise government health services. In essence, cut public budgets and privatise services in health care. Despite Health Ministers repeated assurances to the contrary, the health reforms in New Zealand are clearly pursuing the same strategy established by the Reagan-Thatcher administrations, which continue to be implemented today by the British and American governments, as well as the World Bank and IMF. Thus, New Zealand has much to learn from the American experiences in health care, notwithstanding protests that they are irrelevant to this country.[20]

The health reforms constitute an experiment without any ethical basis. No pilot studies or research were fully carried out. At a late stage, under pressure and with extreme haste, pilot studies were reluctantly started in limited areas. Contrast this with the area health board system, which was developed step-by-step over 15 years with the support of both National and Labour governments. More concerning however, is the realisation that the essence of the reforms is not to improve the health of the country, but rather to transfer the cost of care onto its users.

---

16 Kawachi, 'The American Connnection', 1992.

17 OECD, *The Reform of Health Care Systems, A Review of Seventeen OECD Countries*, 1994, p.11.

18 OECD, *The Reform of Health Care Systems, A Review of Seventeen OECD Countries* 1994, p.11.

19 The agenda did not specify whether this was to be private or publicly provided insurance. As New Zealand has sought and encouraged private insurance it is likely that this is what was meant by the World bank in its report.

20 Kawachi, 'The American Connnection', 1992.

Health care financing Comparisons of OECD Countries

Just as increases in the elderly population varies in each country, so to does the type of financing chosen by the policy makers to fund health care. A visual representation of the different types of systems adopted by countries is presented below to establish the degree of market incorporation introduced by some countries compared to others who remain with government regulated and financed systems. The purpose of this is to compare New Zealand's financing framework with that of other countries.

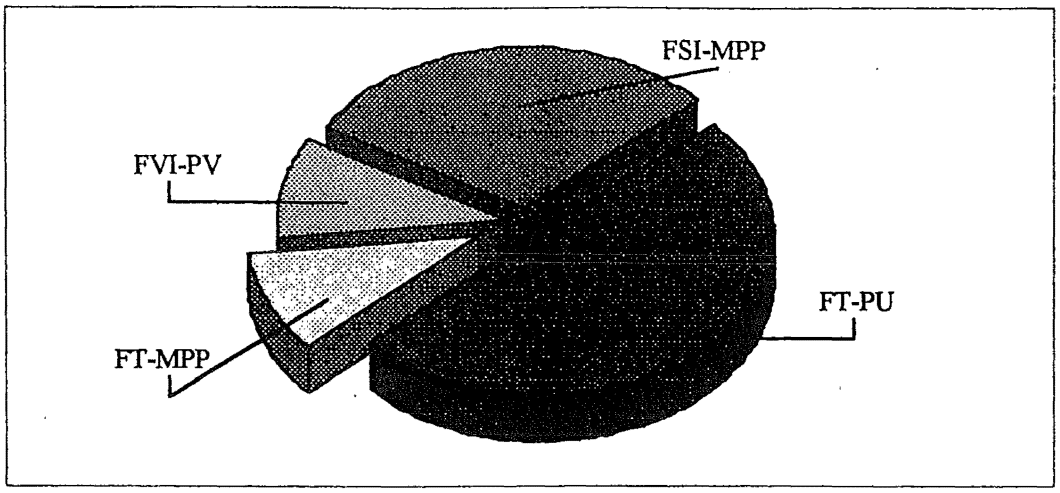

Figure.5 The Combinations of Health Care Systems used by 20 OECD countries

Data Source: OECD 1994.

In figure.5, system **FSI-MPP** is financed mainly by social insurance with mixed public and private providers. Countries which use this system include Belgium, France, Germany, Austria, Japan and Luxembourg. System **FT-PU** is financed predominantly by taxation with mainly public providers. This is the most favoured system and includes 10 of the countries surveyed; Denmark, Finland, Greece, Iceland, Portugal, Norway, Sweden, Ireland, Spain and the United Kingdom. System **FVI-PV** is financed mainly by voluntary insurance with mainly private providers. United States and Switzerland are examples. System **FT-MPP** is financed mainly by taxation with mixed public and private providers. This is the system favoured by New Zealand and Australia.

Within these countries there is a marked variation between those who allow voluntary insurance and those who implement compulsory insurance. Voluntary insurance represents 40-45 percent of health care financing in Switzerland and the United States, while social insurance

accounts for between 56-60 percent of health care financing in Luxembourg and 80 percent in Austria. Nearly all these countries have universal insurance coverage. Austria and Luxembourg (social) have 99 percent coverage. The United States has partial compulsory coverage for the aged and disabled (13 percent of the population) and of certain groups among the poor (10 percent of the population) but achieves coverage of 86 percent of the population if voluntary insurance is included. Yet figures for those without any form of insurance cover in the United States is said to be around 35-45 million or 20 percent of the population.[21]

Comparative data on international expenditure for health care is notoriously complex because of differing definitions and fluctuating exchange rates. Nevertheless, economists have used elected measures to make international comparisons. The measure employed in this examination of health expenditure will be Gross Domestic Product (GDP).[22] Table 2 charts the change in total health expenditure as a percentage of GDP in a number of OECD countries. Cost containment policies have been implemented in New Zealand, as in other countries, with the intention of limiting health expenditures to an acceptable share of national resources. Although this goal of 'an acceptable share' remains elusive in some countries, as it does in New Zealand, expenditure trends suggest that movement has generally been in the desired downward direction.

The growth in health expenditures as a percent of GDP was lower during the 1980s than the 1970s in the majority of the 17 countries reviewed by OECD.[23] This may be good news for the country's economic position, but with increasing costs in health care spurred on by advancements in technology with new procedures and expensive drugs it is hard to believe that spending less amounts on health care is an effective way of meeting the needs of a growing

---

[21]Abel-Smith, *Who is the Odd Man Out: The experience of Western Europe in containing the cost of health care*, Milbank Quarterly,1985,p.17.

[22]The first point to note about this approach is that there is no predetermined optimum percentage of GDP that is appropriate to spend on health to solve the perceived health problems of any country. The main problem associated with making international comparisions of health expenditure as a proportion of GDP is that health expenditure has a price and quantity element. The county with the highter ratio may simply have different internal price relativities (i.e greater expenditure but same or less resources). The United States serves as an example. With health expenditure at 12.4 percent of GDP in 1990, it had the highest ratio of all the OECD countries. But the fact that doctors have relatively higher incomes in the United States means that relatively more has to be expended for any given number of doctors. Further, the fact that the U.S spent 12.4 percent of its GDP on HC does not necessarily mean that the average American is assured of accessibility, equity and quality in terms of HC delivery. Despite its crudity, this ratio is often used for cross country comparison and, will serve the purpose sourght here in this chaper.

[23]OECD, *The Reform of Health Care*; 1992.

Country	1972	1982	1992	1995
Australia	5.8	7.7	8.8	8.6
Austria	5.4	8	8.8	7.9
Belgium	4.3	7.4	8.2	8
Denmark	6.3	6.8	6.5	6.4
Finland	6	6.8	9.4	7.7
France	3.9	4.4	5.4	9.8
Germany	5.7	6.9	8.5	10.4
Greece	3.9	4.4	5.4	5.8
Iceland	5.7	6.9	8.5	8.2
Ireland	6.7	8.4	7.1	6.4
Italy	5.9	6.9	8.5	7.7
Japan	4.8	6.8	6.9	7.2
Netherlands	6.7	8.4	8.6	8.8
New Zealand	**5.3**	**6.9**	**7.7**	**7.1**
Norway	5.9	6.8	8.3	8
Spain	4.4	5.9	7.1	7.6
Sweden	7.5	9.6	7.9	7.2
Switzerland	5.5	7.5	9.3	9.8
UK	4.7	5.9	7.1	6.9
USA	7.6	10.3	14	14.2

Table 2. Total health expenditure as a percentage of GDP in the OECD countries

Data Source: Department of Health OECD Files 1994 & 1997population. The issue is the degree to which New Zealand is reducing its public health care spending and how the compatibility of this reduction with international trends.[24]

The pattern in New Zealand (refer figure 6) shows a large reduction in spending over the last 16 years. The data suggests that the funding structure is shifting.

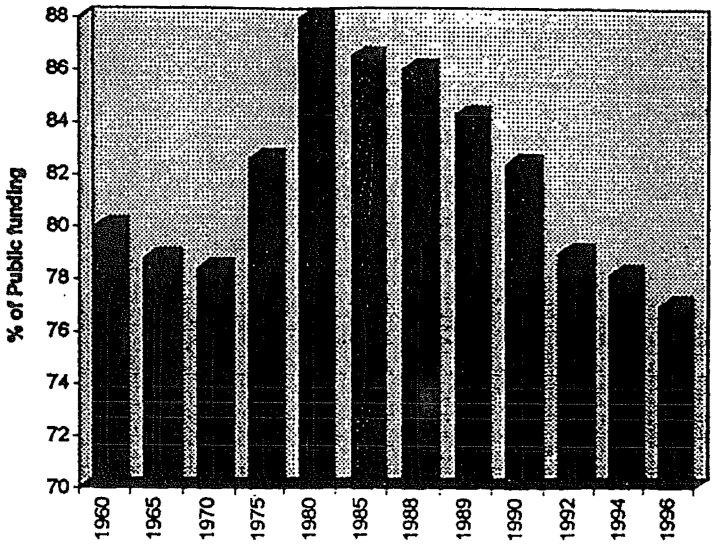

Figure 6. New Zealand's Public funding share of health care expenditure

Data Source: OECD. 1994

[24] See Table 2.

The New Zealand government's gradual withdrawal from funding health care is leading to a situation where public health services are no longer accessible to many people. Keene commented

> 'There is not enough money spent on health. Although National is apt to quote figures showing it is pumping more money into health, the most reliable indicators tell a different story. Annual public health spending on each person in 1995 dollars is slightly less now, around $1400, than it was in 1989 before the start of the reforms. Public health spending as a percentage of GDP at 5.8 (1997) percent is lower than in 1988 and is in the bottom quarter of OECD countries.'[25]

Table 3 charts changes in international public expenditure on health care. By 1980 New Zealand public funding of health care peaked at 88 percent of total health care expenditure. Since then the decline has been steady decreasing as much as 11 percent in a decade and a half to levels lower than in the 1960s.

Country	1960	1965	1970	1975	1980	1985	1988	1989	1990	1992
Australia	47.6	54	55.8	72.9	62.9	71.3	69	69.6	69.6	67.6
Austria	65.3	64.7	62.9	63.7	68.8	66.7	66.4	66.5	66.5	65.2
Belgium	61.6	75.3	87	80.9	82.8	81.8	82.5	82.5	82.5	88.9
Canada	43.1	50.3	70.2	76.6	74.7	74.7	74.1	74.2	74.1	72.7
Denmark	88.7	85.9	86.3	91.9	85.2	84.4	84.2	84.2	84.2	82
Finland	54.4	64.3	72.1	78.6	79.0	78.7	78.6	78.8	83.3	79
France	57.8	68.1	71.7	72.2	78.8	76.9	74.5	75	74.2	74.8
Germany	66.1	70.8	75.7	81	75	73.6	73.4	72.1	72.7	71.5
Greece	57.9	71.1	53.9	61.6	82.2	81	82.6	76.1	76	76.1
Iceland	40	46.2	47.4	58.4	88.2	87	87.6	88.2	87.5	85.2
Ireland	76	76.2	77.8	82.5	88.8	84.7	81.8	83.9	82	76.1
Italy	83.1	87.8	86.4	86.1	81.2	77.1	77.8	76.7	75.9	75.2
Japan	60.1	61.4	64.8	86.1	70.8	72.6	72.4	71.2	71.4	71.2
Netherlands	33.3	68.7	84.3	76.5	74.7	75.1	72.7	72.3	72.6	76.6
New Zealand	80	78.8	78.4	82.6	88	86.5	86	84.3	82.4	79
Norway	77.7	80.6	91.5	96.2	98.4	96.4	95.8	95.7	95.7	94.8
Spain	_	52.6	54.7	70.4	79.9	79	78.4	78.3	78.4	80.5
Sweden	72.6	79.5	86	90.3	94.4	90	89.3	89.3	89.3	85.6
Switzerland	_	60.8	_	66.5	67.5	68.7	68.2	68.2	68.1	67.9
UK	85.2	85.8	87	90.3	89.6	85.8	85.2	84.9	84.5	84.4
USA	24.7	26.2	37	42.5	42	41.8	41.6	41.9	42.4	45.7

Table 3 International comparisons: Public funding share of total expenditure (%)

Source: Department of Health OECD Files

[25]Lydon Keene of the Coalition for Public health in S. Coney. 'Polls suggest health is the one issue that could swing this election', *Sunday Star Times*, 15 September 1996.

Considering that Australia and New Zealand share the same type of financing system, funded mainly by taxation with mixed public and private providers, there is considerable difference in public funding expenditures throughout the 30 years. In spite of attempts to align most elements of New Zealand and Australia's economic and social structures, New Zealand has chosen to follow a similar pattern to the U.K, although public funding figures are not as consistently high.

Internationally, while there is a tapering off of public spending on health care, as shown in figure 7, it is not as extreme as that which New Zealand is experiencing. These trends suggest the role of Government in providing funding for health care globally is being gradually reduced. It can only be assumed that the gap is being filled by the private sector and its associated markets. The trend is adding to other evidence supporting the fact that the private sector is going to play a much larger role in providing health care in the new millennium.

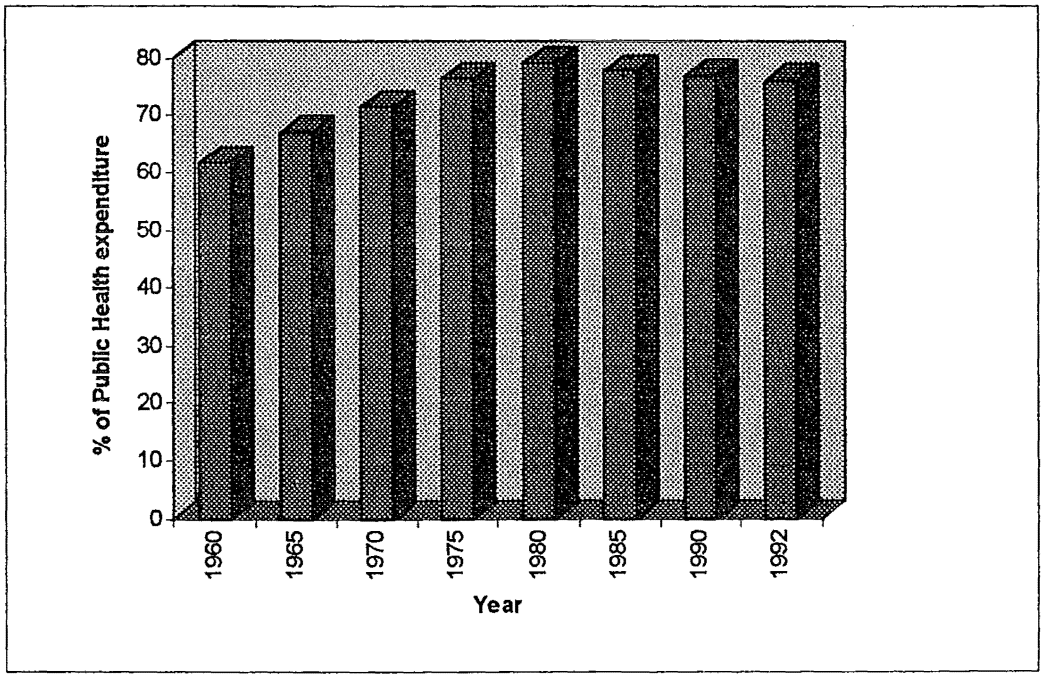

Figure 7 Public Health Expenditure averaged for 21 OECD countries over 30 years

Data Source: OECD The Reform of health care Systems 1994

The Role of the Private Sector in Other Countries: Comparisons & Lessons for New Zealand

Evans contends that advocates of the private market are making their arguments as if the last forty years had never occurred.[26] He states that issues that were contentious in the 1950s and 60s are being dragged out again, with all sorts of previous arguments being dusted off, repainted, and presented as new thinking about the role of the private sector.[27] Evans argues that after several decades of international experience with different mixes of public and private funding systems, the market system of health care has been largely abandoned. 'Private markets have been reduced to a subsidiary role in all developed countries other than the United States, largely on the basis of distributional concerns'.[28] Hsiao gave a recent evaluation of Singapore's experience with medical savings accounts to which he concluded that, contrary to those claims, increasing the role of private financing has led to more rapid cost escalation, an overcapitalised system of duplicated and under-utilised facilities, and rapid increases in physician incomes. Even when patients are paying prices in nominally "free" markets, hospitals compete on technology rather than price. Hsiao described the Singapore funding system as carefully planned and well executed. It was the fundamental theory that was in error. In 1993, Singapore authorities concluded that the health care system is an example of market failure. The government has to intervene directly to structure and regulate the health system.[29] This observation has become so prominent that, given the accumulation of international experience, one could wonder how the government could justify implementing the reforms. But it is significant because it follows a decade long effort, under the most favourable circumstances, to make the market work.[30]

In the developed world, despite wide variations in detail, there is a broad similarity of system characteristics which White has labelled "the international standards" for health care systems.[31] The characteristics are;

A) Universal coverage of the population, through compulsory participation;

B) Comprehensiveness of principal benefits;

C) Contributions based on income, rather than individual insurance purchases;

D) Cost control through administrative mechanisms, including binding fee schedules, global budgets, and limitations on system capacity.[32]

---

26 Evans, 'Going for Gold',1997,p.432.

27 Evans, 'Going for Gold',1997,p.432.

28 Evans, 'Going for Gold',1997,p.432.

29 Rice,'Can Markets Give Us the Health System We Want?'1997,p263.

30 Evans,'Going for Gold',1997,p.448.

31 J.White, *Competing Solutions: American health Care Proposals and International Experience*, Washington, D.C: Brookings Institution, 1995.

New Zealand's system ascribes quite closely to White's 'international standards'. The predominant divergence arises under C) Contributions based on income, rather than individual insurance purchases. While New Zealand's system is based predominantly on health care funded publicly through taxation, this is declining and individual insurance is rising. This is evidenced by Health Ministry figures on health insurance spending which have almost trebled since the beginning of the decade. Total health insurance spending grew from $15.8 million in 1979-80 to $141.7 million in 1989-90 and to $389.6 million in 1994-95.[33]

The United States with the FVI-PV systems[34] does not subscribe to the 'international standards' and, as White points out, is the exception to the generalisation, departing in a major way from the standards outlined in both structure and performance.[35] The same point was made ten years earlier by Abel-Smith who observed that the United States was the "odd man out" among modern health care systems.[36] As such, it provides an enormously valuable point of comparison for New Zealand. What happens if a country does not move toward a central role for government in the financing of health care, or conversely, from New Zealand's perspective, moves away from such a role for government? The decade between Abel-Smith's observation and White's review has reinforced the earlier conclusion. The United States has a health care system that is, by most measures, not only unique in the developed world but also uniquely unsatisfactory. This is not to say that the health care provided in the United States is of poor quality. Generally the quality is excellent.[37] American patients typically express a high degree of satisfaction with their own care. But as a system for organising, delivering, and particularly for financing health care, the American approach is, by international standards, grossly inefficient, unfair, monumentally top-heavy with bureaucracy, and off the charts in both the level and the rate of escalation of costs.[38] It suggests

---

[32] White, *Competing Solutions: American health Care Proposals and International Experience*, 1995.
[33] 'Health insurance spending trebles', *The Dominion*, 9 January 1997.
[34] FVI-PV, Mainly Voluntary Insurance, with private providers.
[35] White, *Competing Solutions: American health Care Proposals and International Experience*, 1995.
[36] B. Abel-Smith, *Who Is the Odd Man Out*, 1985, p.17.
[37] Evans, 'Going for the Gold, 1997, p.434.
[38] Althougth the specific numbers may be controversial, the broad empirical facts do not appear to be in dispute. No one denies, for example, that the uniquely American form of health insurance generates very large administrative costs, much higher than in any other national system. S. Woolhandler and D.U. Himmelstein, 'The Deteriorating Administrative Efficiency of the U.S. Health Care System' *New England Journal of Medicine*, 1991,p.324. have done the most to focus attention on these excess costs; their estimates relative to, say, the costs of administering a Canadian-style universal system, would now be well over $100 billion. Others have generated lower estimates, but the point is that whether unnecessary paper pushing costs Americans $80 billion or $120 billion, the amount is large. Similarly, one can debate whether the number of Americans without health insurance at any point in time is closer to 35 or to 40 million.

that it may be impossible to support a modern health care system predominantly from private funds.[39]

Some could argue that as New Zealand's health care system is approximately three quarters government funded, the American model may not seem so relevant. It is, however, a very sobering warning for increasing the responsibility of the private sector in providing health care to New Zealanders. As control is taken out of government hands and placed with the private sector it becomes increasingly difficult to make amendments to the system.[40] The record of the last forty years suggests that the United States trod the wrong road in trying to rely on a private system to organise and finance health care. The irony is that the rest of the world, which has struggled to reach what now seems to be a reasonably satisfactory system, albeit one needing a good deal of further work, is showing signs of importing American ideas and expanding the role of the private market. The standard claim by market advocates has always been that placing more of the cost burden on individual users will lead to lower utilisation and more careful purchasing by consumers/patients, more competitive behaviour by providers, and ultimately to a less costly, more responsive and more efficient health care system. If this does not occur, it must be because the user charges are not high enough. The international comparative experience of the last forty years is strongly contradictory to this claim.

Whether or not the claim is true, one of the consequences of shifting the cost burden from taxpayers to users is a redistribution of wealth from lower to higher income individuals.[41] American experience indicates that a high level of coverage requires very large public subsidies, both directly for the elderly and poor, and through tax expenditures for those with private coverage. Indeed such public programs like Medicare and Medicaid were established outside the competitive marketplace in order to ensure that their priority - access to medical care services for the elderly and the poor - was met.[42] But the tax expenditure subsidies for private insurance can be, and in the United States are, structured to yield the greatest benefits for people in higher income brackets. At the same time, the tax-supported public program for the elderly has extensive user charges, deductibles and coinsurance built into it in the name of cost control. But these charges are in turn covered, in whole or in part, by private medigap insurance policies or through extensions of employer coverage as a retirement benefit. Such private coverage is highly correlated with income.[43]

---

[39] Evans, 'Going for the Gold', 1997,p.435.

[40] As Hillary Clinton found out when attempting to introduce public HC programmes into what is primarily a private system. Once the private sector has a major role in delivering HC, then the entrenched interests of insurance companies, plus the combined weight of those in the medical profession who advocate it, must be contended with, Evans,'Going for Gold',1997,p.436.

[41] Evans,'Going for Gold',1997,p.436.

[42] Evans 'Going for Gold',1997,p.398.

[43] Evans notes the very poorest are eligible through the Qualified Medicare Beneficiary program for reimbursement of their user charges by Medicaid, if they know about the quality for the program.

The whole system produces much higher costs and a much more regressive contribution structure than would be politically acceptable in any single-payer public system funded from general revenue.[44] But all this administrative apparatus does not come cheap. In an analysis of OECD data by Gerdtham and Jonsson, in which the effects of differences in the relative prices of health care services were identified, it was found that a large proportion of the difference in per capita expenditures between the United States and other OECD countries was a result of higher relative prices of health care in the United States.[45] Americans receive, on average no more care than Canadians, very little more than Japanese, and much less than Swedes. But they pay much more, relatively, for what they get. 'American health care costs more because Americans face greater threats to their health, and need more care...But they do not get much more care, they just pay much more for it.[46]

The extreme case frames the general issue. The expansion of private insurance within a public system of health care finance offers benefits to both providers (higher prices) and upper-income payers (a more regressive financing structure). It therefore supports a potent political alliance. If, in addition, providers are able (selectively) to recruit people into the private insurance system by offering them the reality, or even just the perception, of superior services, this reinforces the financial advantages. However, the complex administrative mechanisms for achieving these redistributional objectives are themselves costly. They inevitably result not only in higher incomes for (some) providers, but also in an increasing flow of real resources into the overhead costs of managing the health care system leading to uncontrolled cost escalation. This in turn generates an administrative arms race as each payer struggles to shift the ever-increasing costs onto others. Such efforts are highly rational, indeed necessary for survival at the level of individual institution. From the perspective of the society as a whole they generate an ever-increasing level of pure waste motion.[47]

Although upper-income Americans may pay a smaller share of the costs of their health care system than they would if it conformed to White's international standards, many of them actually pay more in total because their system is so much more expensive. Public sector spending on health care in the United States, at $1599 per capita in 1994, was greater than in any other

---

44 Evans, 'Going for Gold',1997,p.451

45 Gerdtham, U.G and B jonsson. 'How Does Canada Do It? A Comparison of Expenditures for Physicians' Services in the United States and Canada'. *New England Journal of Medicine*,Vol 323, 1991, Pp.884-890.

46 Gerdtham & Jonsson, 'How Does Canada Do It? A Comparison of Expenditures for Physicians' 1991.

47 A Wildavsky, 'Doing Better and Feeling Worse: The Political Pathology of Health Policy', Daedalus 1977, p.453.

OECD country, except Switzerland, even without accounting for the American tax expenditure subsidy. Canada, for example, with universal public first dollar coverage for hospital and medical care spent substantially less.[48] Americans, therefore pay more in taxes for health care in addition to (or despite) their massive contributions through the private sector.

While health planners in this country try to distance themselves from the American model, overseas observers (backed by recent international studies) confirm our trend toward emulating the U.S policies. William Waldegrave, the British Secretary of Health, singled out the New Zealand health system for its emphasis on 'privatisation' and during the 1991 election campaign he assured the British public that the Conservative Government in Britain would not follow New Zealand's example. Mr Waldegrave's observations were based on what he described as the National Government's decision to limit the range and scope of public health services. By expecting crown health enterprises (CHEs) to operate as successful businesses, the National Government has effectively narrowed the definition of 'health' and simultaneously reduced 'the health service' to a range of commodities which can be bought and sold like other tradable goods such as butter, wool and lamb. This process of 'commodification' stems from neo-classical economics which has dominated the policy agenda in this country since 1984.[49]

A recent international study on the social effects of free-market policies concludes that the rise of monetarism in countries such as the USA, Britain and New Zealand has placed an enormous burden on society in the form of widespread unemployment, increasing social dislocation and an overall decline in economic and social security. In specific social service areas such as health, the theology of market forces, user pays, consumer choice, and targeting was supposed to produce a more efficient service, however in reality social services in countries, such as the United States, have noticeably deteriorated.[50]

In Germany under the FSI MPP system,[51] private insurance premiums are calculated according to age in five year cohorts. The premiums do not increase as the individual ages, so individuals pay more when they are younger, thus setting aside a reserve needed to cover higher costs as they age.[52] In New Zealand, however, there is no such plan. Instead those over the age

---

[48] OECD/CREDES, OECD Health Data 96. Software for the Comparative Analysis of 27 Health System. Paris: OECD Health Policy Unit, 1996.

[49] Borren & Maynard, 'Searching for the Holy Grail in the Antipodes: The Market Reform of the New Zealand Health Care System', 1993.

[50] Borren & Maynard, 'Searching for the Holy Grail in the Antipodes: The Market Reform of the New Zealand Health Care system, 1993.

[51] FSI MPP the system which is financed by mainly social insurance with a mix of public and private providers.

[52] U.Reinhardt, 'West Germany's health Care and Health Insurance System: Combining Universal Access with Cost Control'. Report Prepared for the U.S Bipartisan Commission on Comprehensive Health Care, Washington, D.C June 25,1990.

of 65 pay on average 60 percent more for their premium annually than someone under this age. This is compounded by the fact that the majority of people in this age group are retired and on a fixed and considerably low income. New Zealand's two biggest health insurers, Southern Cross and Aetna Health, have 60 percent and 19 percent of the market share respectively. Aetna's rates have risen, on average, 20 percent annually. Southern Cross has increased its rates on average by 12.5 percent annually, with its largest increase of 20 percent in Ultracare premiums.[53] Just when people feel secure because they have insurance cover for their retirement years, insurance costs force many to cancel their policies. Many elderly are not able to continue paying for insurance which they have held for over 20 years as their fixed incomes do not allow them the flexibility of paying the increasing premiums. Insurance companies can, therefore, make safe profits by insuring people when they are young and fit then force them out when they are older. A plan such as that in Germany may well be valuable in distributing the cost over the lifetime of a person so they pay more when they can and less when their income is fixed.

Private insurance provides coverage for slightly more than 11 million people in Germany and while it has not outlawed private insurance for benefits covered under the national health insurance program, any individual earning more than approximately $3,400 per month can purchase insurance from about forty five private insurers. This alternative coverage represents to many the 'escape valve for the affluent'. Those who purchase private insurance as their sole coverage tend to be single people with high incomes.[54] In New Zealand most medical insurance is bought by people on middle to higher incomes with employer group schemes making up about 50 percent of the market and covering many on lower incomes.[55]

The increasing role of the private sector in the United Kingdom which has the favoured FT-PU system, shows parallels to New Zealand as they develop at similar rates and for seemingly similar reasons.[56] There has been a significant increase in the prevalence of private medical coverage in Britain over the past two decades (see figure 6). Less than 4 percent of the population was covered by private insurance in 1971. Almost a decade later private coverage rates had only increased to 5 percent. By 1989, however, approximately 11 percent of the population was covered by private insurance.[57]

---

[53]Ultracare is a insurance package which is top of the line, giving the holder a comprehesive coverage, citied in P. Love, 'Going Private', *The Evening Post*, 26 Oct. 1996.

[54] Schneider, Markus, Health Care Cost Caontainment in the Federal Republic of Germany, health Care Financing Review 12,no.3 1991 in L.A.Graig, 'Health of Nations', An International Perspective on US Health Care Reform.,1993.

[55] P.Love, 'Going Private', *The Evening Post*, 26 Oct. 1996.

[56] FT-PU, taxation with mainly public providers, the most preferred financing system, used by 10 OECD countries.

[57] P.Love, 'Going Private', 1996.

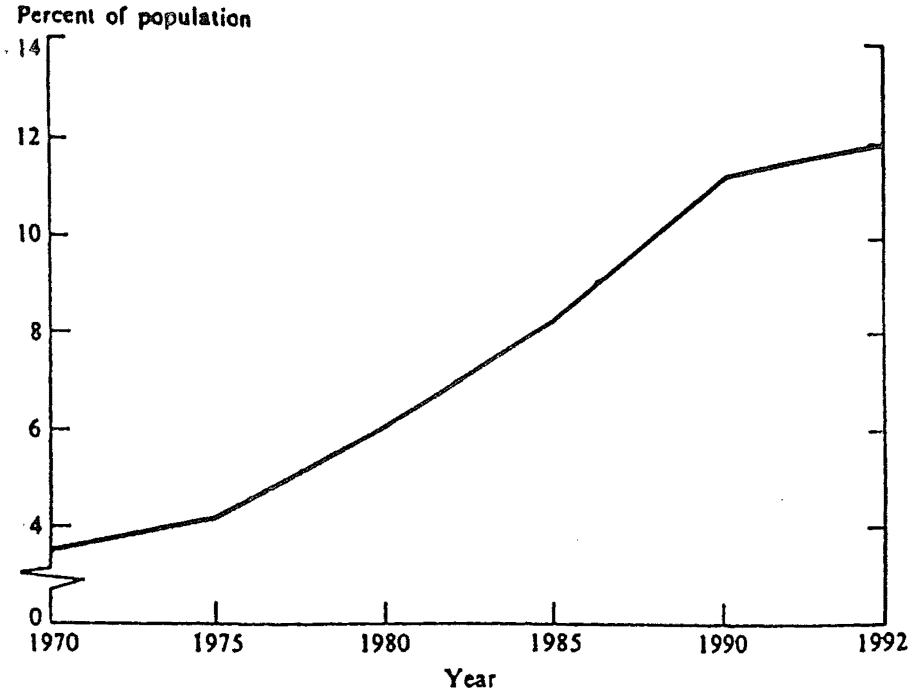

Figure 8. Private Health Insurance coverage in the U.K, 1970-1992

Source: Health of Nations, 1993

By 1991, this has increased to 12 percent of the population.[58] Comparatively, New Zealand has approximately 7 percent of the population insured (in 1998). The creation of the National Health Service (NHS) did not include the outlawing of private insurance for those benefits covered by the national plan, as the Canadian system did. Unlike Germany, where citizens can opt out of the public plan if their incomes are high enough, British citizens cannot opt out of the plan by not paying taxes. Thus, they move back and forth between the NHS and private plans. Private insurance plans allow patients to seek care in private hospitals or even in NHS hospitals that have beds for private patients - known as 'pay beds'. The private sector route enables patients to get around long waiting times for elective surgery. As one policy study noted, 'The private patient pays to avoid waiting, the NHS patient waits to avoid paying'[59]

Tight budgetary constraints have led to waiting lists for particular types of non-emergency surgery in the UK. Waiting lists have been a persistent feature of the NHS since its inception which was in an environment of post-war rationing of all goods and service. Yet public willingness to wait for certain surgical procedures has steadily declined as the 'democracy of the till [became] more attractive than the equity of the queue'[60] It is estimated in the U.K that there are currently

---

58 P.Love, 'Going Private', 1996.
59 P.Love, 'Going Private', 1996.
60 P.Day and R.Klein, The Politics of Modernisation: Britain's New Market Model of General Practice: Do Consumers Know Enough to Make it Work?' Health Policy, No.14, 1989.

more than 900,000 people (55m population) on waiting lists for such procedures as hernia repair, treatment of varicose veins, hip replacements, and cataract removal.[61] Due to the nature of the operations being sought this would suggest that those who are waiting are in the older age group. New Zealand has the same waiting list problem yet it seems much greater if the total populations are compared. In March 1996, 100,000 people (3.5 million population) were reported to be on a waiting list.[62] Percentage wise this means that 1.6 percent of the U.K population is on a waiting list compared to 2.8 percent of New Zealanders. For those, however, who can afford insurance, there is no waiting for health care. The equity of such a system is certainty something to be concerned with.

The increased prevalence of private insurance coverage in Britain can be traced to several factors. First, there is widespread belief that the NHS provides second-class care, due largely to the existence of waiting lists. Further, that there are insufficient services within the NHS causing patients to look elsewhere for care. Increasing numbers applying for private insurance coverage certainly reflects the frustration over having to wait for certain medical procedures. But increasing private coverage is also the result of a patient's desire for control over such specific aspects as the timing of an operation, the particular surgeon and the particular hospital in which the procedure is performed. The second major factor fuelling the growth of private insurance coverage is the increase in employer-provided private insurance. Approximately 70 percent of private coverage is provided by employers. Employer-provided health insurance is a taxable benefit for the employee, the employer pays the premium (which is tax-deductible business expense) and the employee pays taxes on the premium paid on his or her behalf.[63] New Zealand, however, does not have a tax-deductible benefit for employees, rather it imposes a fringe benefit tax of 49 percent onto the cost of such insurance, providing little incentive for companies to provide insurance. Despite this, approximately 60 percent of Southern Cross policy holders have health care cover provided by companies.[64]

Another similarity to New Zealand in the U.K is the infiltration of the private sector into the hospital and nursing home sector. Nursing and residential homes for the elderly are big business for private firms as only 20 percent of the elderly are cared for in NHS geriatric wards.[65] The majority of the aged who are institutionalised are cared for either in public community homes or in private nursing homes. Compared to the acute sector where private providers represent a

---

61 C.Whitney, '*After a Decade of Thatcherism, Have British Values Altered*, New York Times, June9, 1991

62 K.Schereer, The Evening Post; 'Voters most tender on fate of change-weary hospitals', 3 Sep 1996

63 Whitney, *'After a Decade of Thatcherism, Have British Values Altered*, 1991.

64 Interview with Fiona McCloud, Branch manager of Southern Cross Christchurch.

65 This is comparable with New Zealand figures, which show a rapid decline in public provision.

small portion of total health care services, they have virtually taken over the institutional long-stay elderly care sector.[66] Currently only five percent of the British elderly (between the ages of sixty-five and seventy-four) are covered by private medical insurance for acute care coverage. A new law took effect in April 1990 that allows those over age 65 to claim private insurance premiums for acute care coverage as an income tax deduction. If a family member pays for private health insurance for a relative, the individual who pays may deduct it from his or her income tax. This is one government intervention measure which addresses to some degree the imbalance which private sector involvement in insurance brings about.

Conclusions

International trends are showing an increasing role for the provision of health care through the private sector in the 21st century. This is expressed by a number of factors. First, is the gradual and universal decline of public input into health care funding of which New Zealand is one of the more dramatic examples after having had such a high level of government funding in the eighties.[67] Second, to counter this public decline there is a substantial rise in the levels of private participation in a number of countries in the form of insurance companies, private hospitals, clinics, residential homes, and many other areas which the government has withdrawn funding from.

Further findings found that by the first two decades of the new millennium most industrialised countries will be faced with a projected increase in their over 65 population group by an average of 15-17 percent. The result of these changes have meant the implementation of reform policies which are designed to transfer the responsibility of health care provision form the state onto the individual. When comparing the types of financing systems employed by various countries with their health care spending trends it was clear that the type of system did little to constrain the general trend of reduction in public spending and an increase in private. There is however, clear preferences in the particular type of financing system used. 10 OECD countries favour the FT-PU system which is health care financed primarily through taxation with mainly public providers. New Zealand shares the less popular FT-MPP model with Australia.

A third observation was made regarding the reductions in New Zealand's health care spending. Reductions in total expenditure as a percentage of the GDP showed considerable decreases back to its level three decades ago. The average expenditure by OECD countries in 1992 figures was 8.1 percent in 1996 whereas figures for New Zealand were 5.8 percent. This is a significant difference and places New Zealand close to the bottom of the OECD countries.

---

[66] R. Day & B.Klein, *'The Polictics of Modernization*, 'Britain's National Service in the 1980s', London,1989.

[67] With the United States, Belgium the Netherlands and Spain being the exception to this conclusion.

These reductions further supported the argument that the government is transferring responsibility for health care. Since 1980 New Zealand has decreased public expenditure by 11 percent. While globally, trends show an overall reduction in public spending, they are, however, nothing compared to the large change in New Zealand. The void created by the withdrawal of government spending has been filled to some degree by the private sector with total health insurance spending having trebled in a decade and a half. The problem that arises in the United States is that there is a large dependence by the elderly on the state to pay for their care, with public funding from the federal government coming through Medicare and Medicaid. It shows that the private sector is not capable to supply the necessary HC to the elderly.

Lessons learned from overseas experience comes firstly from Singapore where the implementation of market mechanisms in health care failed, resulting in rapid cost escalation, over capitalisation of the system, under-utilisation of facilities and a rapid increase in physicians incomes. The environment had all the right variables to make it work, it was the fundamental theory that was seen to be in error. In the United States it is shown that large scale private sector involvement in health care has lead to higher costs (with a GDP spend of 14% health care annually), extreme difficulty in controlling the system and major distributional concerns, not to mention the most notable effects. Striking resemblance's can be seen in the rise in health insurance between the U.K and New Zealand. However, the U.K system has certain mechanisms in place, such as employer incentives and tax deductions, for the elderly to balance up the inequity which the private sector brings with it. It appears also that the role of the private sector internationally is seen not as providing an essential mechanism for health care delivery to all, but rather 'an escape value for the affluent'. This in itself should set the alarm bells ringing for New Zealand as private sector involvement is seen to be encouraging the concept of a two tiered system. Worse still, few mechanisms have been installed, as have been in other countries, to provide some form of safety net for those groups unable to afford to pay.

CHAPTER THREE

Reforms, Ideology and the Coalition Government

This chapter deals with three important changes, the first of which is the experimental nature of reforms which have been implemented in New Zealand, beginning with the minor amendments of the 1980s and later to the fundamental adjustments which marked the 1990s. It is imperative that the circumstances surrounding the reforms to New Zealand's health care system is given the attention it deserves as it is a result of them that the private sector is becoming an increasingly important part of health care financing today. The second change to occur is the adoption of neo-liberal ideology in policy making and the manifestation of this in health care policy. The third change, is the formation of a Coalition Government between National and New Zealand First, and the development of their combined health proposal. The chapter seeks the answers to a number of questions as to each of these three changes. First, in what way were the reforms experimental? Second, what role does neo-liberalism play in the creation of health care policy? Third, what has been the justification for the reforms in health care? Fourth, what are the coalition government's plans for the private sector and its role in health care?

Experimenting with New Zealand's Social Policy

The Fourth Labour Government paved the way for social policy changes under National. Although Labour made no dramatic social policy reforms of its own, National's welfare state cutbacks, privatisation and user-pay reforms followed the pattern introduced under the Labour Government's initiatives, even if going far beyond them.[1] Piecemeal erosion of the welfare state under Labour meant that 'by October 1990 the structures were in place whereby a change in government, or of political strategy, could see the system virtually decimated overnight'[2] The social security changes introduced by Labour created a political and ideological climate in which the December 1990 cuts and the 1991 Budget changes were possible.'[3]

---

[1] C.James, *New Territory*, Bridget Williams Books, Wellington, 1992,p.139.

[2] J.Kelsey, *Rolling Back the State*, Bridget Williams Books, Wellington, 1993,p.137.

[3] M.O'Brien, & C.Wilkes 1993, *The Tragedy of the Market*: A Social Experiment in New Zealand, The Dunmore Press, Palmerston North, p171. In its six years in office from 1984, New Zealand's fourth Labour government made limited progress in its attempts at reducing the burden of these ongoing commitments. In 1984 it imposed a tax surcharge on the income of better-off

At around the turn of the century, Pember Reeves, New Zealand's first Minister of Labour, described the Australasian states of this time as a 'social Laboratory' in which the parties of labour fashioned radical experiments for the greater edification of the world.[4] Such experiments involved using the instruments of state control to achieve economic and social objectives and included many of the central policy institutions that have made these countries distinctive among the nations of advanced capitalism. Almost a century later, in the 1980s and 1990s the governments run by both Labour and National set out to transform the society and political economy once again. Now, however, in response to changes in the organisation of the international economy the theoretical focus was reversed with the rhetoric of policy innovation being directed to deregulation and rolling back the state.[5]

It is this contemporary process of political and policy change that has been called 'The Great Experiment'. Clearly the 1980s were a period in which economic crisis constrained the ambitions of reforming governments of left and centre in all OECD countries. The two typical responses were an initial defiant stand against economic reality followed by a constrained acquiescence (France and Greece), or an attempt to limit the damage caused by economic status (most other nations) with moves toward deregulation when all else appeared to be failing (Denmark, Sweden). Arguably the Socialist government in Spain was among the more active in introducing neo-liberal economic policies, but this must be seen in the context of its need to sweep away the remnants of reactionary economic regulation and simultaneously preside over the expansion of the welfare state along familiar continental European lines.[6] Australia and even more New Zealand were the only OECD nations in which Social Democratic/Labour governments sought to actively transform society and economy toward a 'more market' model on a scale comparable with the ambitions of the right.

---

superannuitants to recoup some of its payments, though it did legislate to raise the qualifying age starting early next century. The Labour government also attempted to ease its heavy debt servicing obligations by refinancing some existing expensive debts at lower cost and, more dramatically, by selling off a wide range of government perations ('privatisation') and using the proceeds to retire public debt. Yet these efforts were only partially effective because health, education and social welfare spending rates continued to increase. Furthermore, the budget remained in deficit, forcing the government to take out further loans to bridge the difference between its taxation and trading revenues and its faster-growing expenditures. H.Gold, *New Zealand Politics in Perspective*, Ed3, 'The Setting', Longman Paul Limited, 1992.

[4] Pember Reeves 1902 as cited in 'Introduction: Setting the Scene for Economic and Political Change The Editors,' Castles,F.G, Gerritsen.R, Vowles.J, Auckland University Press ,*The Great Experiment, Labour Parties and Public Policy Transformation in Australia and New Zealand,* 1996 p.1.

[5] P.Kelly, *The End of Certainty: The Story of the 1980s*, Allen and Unwin, Sydney and James,C. 1992, *New Territory,* Bridget Williams Books, Wellington.

[6] G.F,Castles, 1995, 'Welfare State Development in Southern Europe', West European Politics, vol.18, no2,P.291.

When National came to power in 1990 it was determined to ease the countries heavy debt servicing obligations and improve the country's balance of payments position. National announced wide-ranging cuts in welfare spending, lowering nearly all benefit levels virtually overnight and tightening eligibility requirements, as well as introducing higher health charges and reduced spending on housing and defence. In its 1991 Budget, National further raised health charges for middle and high income earners and also moved to contain expenditures on national superannuation by freeing current rates for two years and by gradually raising the age of eligibility. By curbing the growth of public expenditures in these areas the National government aimed to reduce future deficits, government borrowings and debt obligations, so as to avoid raising tax rates. All of this has been done.

However, opponents voiced their concerns about the experimental nature of the reforms and how a lack of experience internationally made changes in New Zealand all the more cautionary.

> Several countries including New Zealand and Sweden are moving towards competitive contracting and managed markets before the full effects of the contract model have been evaluated...they are the more remarkable in view of the lack of unanimity among academic observers about either the beneficial effects of such competition as has occurred, or the potential benefits of a still more competitive market.[7]

Overseas advice and recommendations purported that reforms should be expanded from commercial areas through to social policy. As Jean-Claude Paye, former OECD secretary general said

> 'you have to move on a broad front. You can't select one or two domains for reform. Reform should not be limited to economic matters, but should include social areas, like the labour market, health and education.'[8]

So the experiment was comprehensive in that the market was introduced into both economic and social policy arenas on the advice of international economic advisers despite the fact that it was untried and untested.

Why Reform the Health System?

The governments fundamental justifications for the health care reforms included improvements in management, more effective and efficient use of resources, clearer lines of

---

[7] OECD,1994,p34

[8] J.Kerr, 'Achieving a positive economic direction in Business Roundtable,*'From Recession to Recovery*, September 1992.

accountability, cost-containment, and greater choice of services to consumers.[9] The government's motives are said to be a result of severe fiscal constraint, the strong devolutionary tendency of the state in the latter part of the 1980s, and the struggle to establish biculturalism. Although National came into office promising to maintain and improve the area health board system put into place by Labour, it swiftly set about enacting a different agenda. At his first meeting with Ministry of Health officials the new Health Minister Simon Upton, made it clear that he was going to be guided not by the Ministry's briefing papers but by Treasury's. The result was the *Health and Disability Services Act* 1993 which abolished elected area health boards and replaced them with the system of Crown Health Enterprises (CHE) and private health care providers competing for funding disbursed by Regional Health Authorities. This model, however, has failed to evolve into what the government intended.

The National government claimed in the Green and White Paper that there had been a cost explosion in health care.

> Between 1980 and 1991, the Department of Health's budget increased from $1.1 billion to $3.8 billion, an increase of some 27 percent more than the increase in consumer prices over that period.[10]

There are, however, deceptive elements to these figures. First, the increase was from 1.121 billion (nett) in the March 1980 year to $3.807 billion in the June 1991. These two dollar amounts are not quite comparable because in the latter period the Health Department had to pay new levies, including superannuation contribution, fringe benefit tax, rent on premises and GST. Nevertheless, taking the figures at face value and deflating them by the consumer price index (which increased by 215 percent over the same period) gives a movement of 7.7 percent, so it is unclear where the 27 percent came from. Secondly, the population grew by 8.4 percent over the same period.[11] Therefore, using the Green and White Paper's measure, government spending on health per head, adjusted by the consumer price index, actually fell by 0.7 percent over the last decade. This means that for more than a decade governments have been reducing their involvement in health funding. This reduction has been backed up by Neutze and White who state that the Ministry of Health figures quoted by the Director of Health,[12] were misleading and that from 1989 to 1997 there has been an effective reduction of $106.6 million in health care funding.[13]

---

9 OECD,1994, p.240.

10 S.Upton, *Your Health and the Public health*, Green and White Paper, Minister of Health, 1991, Pp.7-8.

11 J.M.Neutze and H.D.White, Cardiology Department, Green Lane Hospital, Auckland, 'Comparing Health Expenditures', *New Zealand Medical journal*, 11 October 1996, p.388.

12 Dr Karen O Poutasi is the current (1998) Director-General of Health in New Zealand.

13 Neutze & White, *New Zealand Medical journal*, 1996, p.388. Neutze and White provided evidence to prove that a letter written by Poutasi on health funding (K.O Poutasi, Comparing health

The gap left by the withdrawal of government funding has been filled by the private sector, with the cost of health care shifting rapidly from public to private. Between 1980 and 1991 private health insurance increased from 1.1 percent of total health expenditure to 3.5 percent. By 1996, this figure had almost doubled to 6.1 percent. Converted into dollar terms $15.8 million was spent on private health insurance in 1980, and in 1994 this figure was $389.6 million.[14] The amount financed out-of-pocket by individuals increased from 10.4 percent to 14.5 percent in this same period and in 1996 to 16.8 percent. The introduction of health reforms will only serve to further these trends.[15] Quite contrary to the Green and White Paper, New Zealand has been unquestionably successful in containing costs to the detriment of provided publicly health care. The alleged blow-out in health care expenditure is seen as more of a myth than a truism.[16] One of the great strengths of New Zealand's health system is that there is a single dominant funder, the state. It has been able to hold expenditure by using its monopoly position as a bargaining strength in paying for or purchasing health services. This system has also been responsible for providing a high degree of equity to the envy of many other countries for over half a century[17], so why the move away from this successful model?

The belief by the National party was that the policy of structural change should be in itself sufficient to drive a change in economic performance. National believed that the individual elements of an economic liberalisation programme would add up to a systematic improvement in performance of the economy. The framework in place represented a relatively unsophisticated comparative static view and envisaged the economy moving from one low performance growth path onto another high performance path. The framework, however, appears to had taken relatively little regard to transitional issues, like the loss of output during the transition, the flexibility of adjustment mechanisms, the timing and sequencing of measures, and the hystersis effects. It also paid little attention to distributional issues, such as the costs of adjustment, the relative winners and losers in the transitional process and whether the losers should be compensated.[18] Reform implementation was rapid. Given the urgency of

---

expenditure,[letter] NZ Med J 1996;109:325-6) contained 'serious distortions'. Neutze and White contend that "Poutasi's presentation is similar to the repeated publications by government. Both distort the true situation and confuse the public. We would hope that the Director-General of Health sees her role not as supporting a given political stance, but as trying to achieve the best possible health system in New Zealand. As such she has an absolute obligation to present expenditure trends in an honest and transparent fashion which will be understood by all the public.

14 'Health Insurance Spending trebels', *The Dominion*, 9 Jan 1997

15 R.Bowie, Uncovering the health expenditure myth, Health Reforms - A Second Opinion,Health economist 1992.

16Bowie, Uncovering the health expenditure myth, Health Reforms,1992.

17Bowie, Uncovering the health expenditure myth, Health Reforms,1992.

18Bollard. A,The Political Economy of Liberalisation In New Zealand, Working Paper 93/2 - New Zealand Insititute of Economic Reserach 1993. p.29.

the situation, there was a certain impatience with such issues. Treasury and other advisors appear to have recommended to government that with an elected term of only three years, they should make maximum use of any political honeymoon and cram in as much reform as legislatively possible. On the basis of the New Zealand government's post war inability to maintain a consistent long term policy stance, the Treasury clearly doubted the chance of sustaining a gradual programme for any length of time necessary to deal with the above issues. In addition Treasury felt a speedy programme was necessary to maintain credibility in the reform, because there were pressing problems such as mounting debt.[19]

The government accepted this advice. Along with Treasury it anticipated some significant transitional disruption to the economy, though probably not so severe or long-term as actually occurred. As a consequence the government launched onto a fast track reform programme. The speed was constrained by the ability of departments to analyse policy alternatives, of the Crown Law Office to write law and of Parliament to enact it. It was not constrained by any self imposed requirement to consult with industry or other groups. The reform programme remained in place during 1984 - 87 term despite poor economic indicators and rising unemployment. Paradoxically, however, the speed of the reforms meant the full costs did not become apparent before the election. Labour was re-elected in 1987 promising to finish the reforms. But after the dismissal of Roger Douglas the programme continued at a slower pace and more controversial decisions such as major privatisations were made tentatively. The Labour government made little attempt to extend its reforms into the growing area of social services. In 1990, under a newly elected National government, the reforms were continued under Ruth Richardson as Minister of Finance, then Bill Birch. The Coalition agreement derived from the 1996 election saw Winston Peters continuing the philosophies of his predecessors. The National government programme concentrated efforts on reforming social services and reducing the macro economic deficit. This programme has proved increasingly unpopular with the electorate which seems to be suffering from reform fatigue.[20]

In 1990 a referendum on the electoral system delivered a blow to both National and Labour with a resounding vote to change the voting system to MMP. This might also be seen as representing a vote of no confidence in the radical economic change. National's attempts at completing the reform process continue but have run into growing opposition from the media and public. In addition, there have been fracturing of party loyalties and the formation of the Alliance party which seeks to turn around the reform process. While there is less appetite for continued reform, many of the reforms in place are not easily reversed.[21] International trends and the entrenchment of the current system, not to mention the lack of finance available to

---

[19]Bolard, The Political Economy of Liberalisation In New Zealand, 1993, p.30.
[20] L.Bayliss, Prosperity Mislaid: Economic failure in New Zealand and what should be done about it, GP Publications 1994, Wellington, p.35.
[21] Bayliss, Prosperity Mislaid: Economic failure in New Zealand and what should be done about it, 1994, p.35.

instigate any major overhaul means that it is more convenient to grapple with the current system than return to and remodel the old one.

The Business Roundtable in New Zealand believed that many areas of policy were neglected because they were difficult or politically sensitive.

> Government is still facing immense difficulties, for example, in modernising bureaucratic and unresponsive education and health systems. The Gibbs and Carr taskforces concluded that hundreds of millions of dollars of extra value could be derived from resources used in the health sector, yet the government reforms in this area remain fiercely contested.[22]

The health reforms have provided an environment where a few entrepreneurial health professionals have established businesses to provide health services. But it is dishonest to pretend they have provided a workable model for the provision of the vast bulk of health services. There is scant evidence of the health reforms improving the overall health status of the majority of New Zealanders. Indeed, diseases often associated with poverty, eg meningitis and tuberculosis, are increasing. Nelson-Marlborough Health Services no longer provides public hospital wards for the long-term care of the elderly and public health nursing services are facing cuts. For a few, namely the wealthy, the health reforms have made a positive difference. For the vast majority of New Zealanders, particularly the more vulnerable members of our society - the elderly, the unemployed and low paid - they have meant more expensive and less accessible health services.[23]

> In considering the reforms in a number of government provided areas, it would appear that the CHEs were created as SOEs so that they could ultimately be sold off, like the Railways or Telecom. The health reforms had aims which were consistent with National's approach in other spheres, whether it was education or utilities such as power. National could be seen to be driven by its ideology, which was wedded to the fundamentals of the market.[24]

The health reforms created a market in health with competition between providers. It could easily appear that this had no greater purpose than promoting the belief that competition is a pure good in its own right and that "the market" should be the prime means of distribution of goods and services for health care. Some could and did contend that improved health status for New Zealanders hardly came into it.[25]

Allied to this, it would seem that National wanted to disentangle itself from the state provision of public services, whether it was housing, prison or health. It could easily appear

---

[22] R.Kerr, 'Rattle of Teacups', *From recession to recovery - the Business Round Table*, Wellington, September 1992,p.71.

[23] Health Reforms, *The Nelson Mail*, 1 August 1997.

[24] S. Coney, 'Despite the talk, little changes in health system', *Sunday Star Times*, 12 Jan 1997.

[25] Coney, 'Despite the talk, little changes in health system', 1997.

that publicly provided health care was destined to become a welfare service, a safety net reserved for those in the lower socio-economic group. Hence user pays was implemented at the public hospitals and, consequently, public health services suffered forcing people to buy health insurance if they could afford it. The key mechanism for creating the health market was the RHAs. They held the purse strings and public and private providers competed to sell them services.[26]

Under the National Government public spending on health has fallen in real terms.[27] A Ministry of Health report marked down many aspects of the health reforms, accusing the Government of making poor political decisions and throwing money at problems in an ad hoc fashion. Although health funding 'improved' under the Minister of Health, Mrs Shipley, the report stated that "funding is less generous now [1996] than it was in 1988-89". In real terms, public expenditure was 10 per cent lower.

Most growth in health spending had been in the private sector. Between 1980 and 1995, public expenditure grew by 0.4 percent a year in real terms, while private spending grew at an annual clip of 5.8 per cent.[28] It appears that even after four years of reforms many New Zealanders are concerned with the state of the health system.[29] National has tried to soothe public concern by producing more money. Since 1993, it has found hundreds of millions of extra dollars for health services. It continues to insist its health reforms are on the right track and that all it needs is more time to deliver the benefits. Its opponents insist that the competitive nature of the health reforms is the main problem coupled with serious under-funding.[30]

National's reforms created four regional health authorities as purchasers of services in a preparatory step towards producing more competition. It is widely felt this has not been a success. The RHAs are seen as remote, unresponsive and overly bureaucratic. In the past two years, the running costs of RHAs have swollen by 40 percent, while Health Ministry expenses have also grown by 11 percent in the past year. After cutting the Ministry's staffing by 20 percent in 1989 when he was Director General, Dr Salmond has been galled to watch the RHAs swell in size.

> 'Each RHA has about 100 people, they're bursting at the seams. If you put those 400 people in one place, the system would be a lot more cohesive and have a lot more horsepower. We are running four separate health systems.

---

[26] Coney, 'Despite the talk, little changes in health system', 1997.
[27] B. Orsman, Ministry attacks health decision, by Bernard Orsman, *New Zealand Herald*, 12 April 1997.
[28] Orsman, Ministry attacks health decision, 1997.
[29] K. Scherer, Voters most tender on fate of change-weary hospitals, *The Evening Post*, 3 Sept. 1996.
[30] Scherer, Voters most tender on fate of change-weary hospitals, 1996.

> Everyone develops their own version of the wheel, which is extremely inefficient.[31]

Dr Salmond says the belief that competitive markets can deliver health has led to the dismantling of the structural framework that held the system together.

> "The analogy is the Olympic Games. You can have a whole bunch of skilled people who can row but someone has to make sure that rowers get to the venue and someone has to make sure the boats get there and there have to be some rules for competing. We've lost all that structure. We're not talking about top-down central government but social leadership and framing up. There has to be a process for how people talk to each other so they don't just mill about.[32]

There are recognised advantages in returning to a tighter national framework with greater national direction. Dr Salmond claims it would "give a clearer focus to our major national activities that have got fragmented, such as definitions for services, quality measures, information systems, workforce activities and research and development."[33] One of the casualties of the health reforms was the elected area health boards. They were replaced by the RHAs and CHEs whose board members are government appointees, primarily from business backgrounds. This was a deliberate tactic to reduce the lobbying power of communities and to prevent "capture" by provider groups. As a result, says Dr Salmond, " we've had a health system run by politicians and managerialeties. It's got to be democratised."[34] Toni Ashton, a health economist at Auckland School of Medicine agrees stating "if you don't talk to providers, you flounder around in the dark. The idea was to depoliticise the system but the Government hasn't been able to keep its hands off. It's kept on intervening."[35]

The United States has found that polarisation means that the 'haves' are quite content because they're becoming better off at the expense of the poor. The poor, on the other hand, have become increasingly disenfranchised without their own political voice. Therefore, as Kawachi states,

> we might arrive at an overall impression that the country is doing quite well, when in fact, a sizeable percentage of the population has become an underclass, has ceased to actively participate in our society, and because of the situation these people find themselves in, few are complaining.[36]

---

31 Scherer, Voters most tender on fate of change-weary hospitals, 1996.
32 Scherer, Voters most tender on fate of change-weary hospitals, 1996.
33 Scherer, Voters most tender on fate of change-weary hospitals, 1996.
34 Scherer, Voters most tender on fate of change-weary hospitals, 1996.
35 S. Coney, 'Parliamentary Elections', *Sunday Star Times*,15 Sept. 1996
36 I.Kawachi, an assistant professor in the shcool of public health at Harvard Medical School, Boston, in J. Saunders, *The nation with a heart of stone*, 8 Feb 1997.

Many of the policies introduced in New Zealand in the 80s were justified by the trickle-down theory, the idea that the rising tide would lift all boats together. On the contrary, Kawachi's research suggests the rising tide will in fact drown up to 20 percent at the bottom as a result of the distribution problem. Dr Salmond commented:

> The illusion created to justify the reforms was that we were profligate with health money. That was not so, we hovered around spending 7 percent of GDP. By Western standards, that is pretty modest. A country like ours might choose to go to 8 to 10 percent like Australia or Canada and there's no reason why we shouldn't.[37]

While the Government defends its line of change with the arguments presented above, the accompanying statistics tell a different story. There is a general agreement that not enough money is spent on health. Although the government is prone to produce figures showing it is pumping more money into health, the most reliable indicators tell a different story. Annual public health spending on each person in 1995 dollars is slightly less now - around $1400 - than it was in 1989, before the start of the reforms. Public health spending at 5.8 percent of the GDP is lower than in 1988 and is in the bottom quarter of OECD countries. These figures are sobering yet the government is convinced that the theory behind the reforms if solid. The next section looks at the theoretical foundation of the reforms - neo-liberalism which has played a fundamental role in the new right ideology of the current government.

The National Party's Ideology

The dominant analysis of the modern state that derived from post-war pluralist thinking assumed a balance between the political and the economic within a self-contained nation state. The context in which this analysis emerged, the post-war or Keynesian accommodation, began to collapse on an international scale in the late 1960s and early 1970s. Neo-liberalism emerged to fill the policy vacuum left by this collapse. It was not a sudden transformation, rather an alternative which, while usually dismissed, drew on a long intellectual heritage and was given an organisational focus after the Second World War. Its strength in the 1970s lay in three factors. First, proponents of the theory had argued for many years that just such a collapse of state-run collectivism would occur. Secondly, neo-liberalism offered a complete alternative package for government based on a reduced state function, free markets, deregulation and privatisation, and an ideological commitment to the individual rather than to society.[38] Third, this package served the interests of some very powerful groups.

---

[37] Dr George Salmond former Director-General of health, now director of the Health Services Reserarch Centre at Victoria University in S. Coney, Polls suggest health is the one issue that could swing this election, *Sunday Star Times*, 15 Sep 1996.

[38] N.Haworth, Neo-liberalism, economic internationalisation and the contemporary state in New Zealand, in A.Sharp, *Leap into the dark*; 'The changing role of the state in New Zealand since 1984',p.27.

Neo-liberalism makes up one of the main strands of New Right ideology.[39] This ideology, which is based on a belief in self-reliance, individual responsibility and the market, is essentially hostile to a Welfare State built on a 'social equity model'. The latter is premised on the idea that health care is allocated according to need rather than demand and that scarce resources are rationed by providers according to unspecified criteria.[40] It also places great emphasis on the value of equality and its achievement through centralisation and the public ownership of the means of production. Providers in this context are paid directly by the state, usually through salaries.[41] Neo-liberalism, by comparison, places its faith in the 'market economy model' and consumer choice as a means of allocating care. Emphasis is placed on freedom of action and personal responsibility. State involvement is rejected because it is perceived to constrain freedom and create dependency. Thus, it is believed that if people are offered state benefits, such as health care, it weakens their desire to look after themselves and erodes their moral well being and voluntary expression of social concern. On this view, charity rather than the state is seen as the proper vehicle to meet social problems.[42]

The mechanisms through which such freedom and personal responsibility are pursued and achieved are private ownership and rewards. Health care is seen as part of the reward system and, as a result, access to health care is determined largely by the ability to pay. Likewise, providers of care are directly rewarded according to market forces mainly through fee for service payments.[43] Hence, on this approach, the consumer is sovereign and health care is based on demand expressed through the market, whereas in the 'social equity model' health care is based on need, with resources being distributed centrally on grounds of equity. Those who argue that health care is best funded through the market see the market model having a number of advantages which reflect the assumption that health care is an ordinary commodity. First, it is claimed to be more responsive to consumer preferences, contributing to innovation and equal treatment. Second, rationing by price is said to be a fairer system of meeting need than rationing in other ways. Third, it arguably more flexible and brings about a large expansion of hospital-based services. Finally, the claim is that it removes bureaucratic inefficiency, involving greater consumer and provider responsibility.[44]

The "Sustainable Funding Package" report showed National had a poor record in matching service, access and quality levels with funding. The blame for this was placed squarely on politicians and a lack of clarity in policy, not the structure of the health system.

---

39 T. Flynn,'The New Right and social policy', *Policy and Politics*, ,1989, Pp.97-109.
40 R. Klein, Private practice and public policy: regulating the frontiers. In McLachlan, G and Maynard,A. (eds) '*The Public/Private Mix for Health*', NPHT, London,1982, Pp.95-128,
41 Klein, Private practice and public policy: regulating the frontiers, as cited in McLachlan & Maynard, *The Public/Private Mix for Health*, 1982,Pp.95-128.
42 D.G.Green, *Working Class Patients and the Medical Establishment*, Gower, Aldershot,1985.
43 Klein,'Private practice and public policy: regulating the frontiers', 1982,p.40
44 M. Calnan, S. Cant and J. Gabe, *Going Private: Why people pay for their health care*, Open University Press, Great Britain, 1993.

The report said that over the past three years the health and disability sector had suffered from frequent funding crises which had been dealt with by way of ad hoc cash injections.[45] The overall concern was to develop a coherent system for funding, purchasing, and delivering health care. Reforms have inevitably impinged upon the assumptions of the welfare state. Although the welfare state provided all New Zealanders with equitable access to health care of high quality, equity of access is not the same as equitable health opportunity or outcome. In the 1980s such inequities began to be acknowledged. Sometimes differentials in health and social indicators were interpreted in ethnic as well as socioencomic terms. Mounting evidence showed that, although the health experience of the Maori population (which accounts for 12.5 per cent of the New Zealand population) paralleled that of the non-Maori population, significant and avoidable inequities remained, such as economic hardship and remoteness from the areas with medical facilities.[46] These insights coincided with renewed recognition of the Treaty of Waitangi (1940) between Maori and the British Crown as the nation's founding "charter" and as the enduring basis for equal partnership and cultural development.[47]

If National continues to follow that market direction, the private health sector will progressively grow. Mechanisms for accelerating privatisation are being put in place in the form of GP budget holding and managed care organisations. In a future with National in charge, we could see a variation of the "alternative health care plans"[48] and an introduction of the voucher system outlined by Simon Upton in his Green and White Paper but put on hold in 1992. The public would enrol with an insurance-based or other style of managed care plan, responsible for providing their health care.

> I can't see National moving away from their basic approach that health is a commodity that people should pay for if they can. They want to move people off the public health system.[49]

The Nurses' Organisation even accuses the Government of running down hospitals to put people off public services. 'They want people to take out private insurance'.[50] Doctors would like to see the changes working but there's a feeling that they haven't achieved the promises of a brave new health system. Nurses would welcome a return to the former system.

---

45 OECD,1994,p.234.
46 E.W. Pomare and G.M. De Boer, Towards Responsiveness - Objective Setting and Evaluation/Me Penapena - Nga Whainga atu mo nga hua a kitea ana.(1989).
47 OECD,1994,p.228.
48 See appendix B for detail of the Green and White Paper
49 As quoted by Dr Salmond, former Director-General of Health as cited in Coney, *Sunday Star Times*,1996.
50 Brenda Wilson, national director of the Nurses Organisation,cited in *Sunday Star Times*, 15 Sept, 1996.

> They are demoralised and have complained about unsafe staffing levels without getting anywhere. Serious nursing practice incidents have increased by 2460 percent in five years from 1990.[51]

However, to change tack every three or five years is not satisfactory either. The Former Director-General of Health[52] supports a return to a system similar to the old area health boards but says the transition would need to be carefully managed.

> "We don't want a convulsive leap back. When the RHAs were set up, there was an enormous exodus of trained managers, who understood the health environment, to Australia and other countries. We'd have a managerial vacuum in terms of running a public health system so we'd need to invest in training and support."[53]

This view is supported by key health policy advisers.

> "You can't alter things in health quickly. It's like an ocean liner. You start turning the wheel and the ship will eventually turn around some kilometres down the route. The damage of the last few years shouldn't be underestimated. A lot of people are gone, the institutional memory is gone, relationships are gone and faith in the system is gone. We'll have to involve the public and health professionals in a genuine consultation about how we get to where we want to be."[54]

Coalition Governments Direction

With the arrival of New Zealand First, one of the more pressing questions was the influence the junior partner would have on National's reform policy. Those who hoped for a minor revolution were to be bitterly disappointed. No sooner had Treasurer Winston Peters delivered his first Budget than Opposition parties launched a furious attack, claiming its promises of future spending ignored economic reality and failed to address critical social needs. The Treasurer had announced $903 million in additional spending for the financial year beginning in July 1997, with health taking about a third of that and education a close second. But Labour and the Alliance accused him of lacking vision and continuing 'obscene' National Party policies. Peters delivered a Budget with a careful balance of tight fiscal management measured against the promise made in the coalition agreement. The Treasurer said the Budget incorporated 'a dramatic percentage of delivery on promise. No government can be expected to deliver on every single one in its first Budget. But Labour health spokeswoman Lianne Dalziel

---

51 Wilson, *Sunday Star Times*, 1996.
52 Dr George Salmond, now director of the Health Services Research Centre at Victoria University, cited in Coney, p.34.
53 Salmond, as cited in Coney, *Sunday Star Times*,1996.
54 Lyndon Keene of the Coalition for Public health.

said it was 'window dressing' which, as well as disappointing the elderly, would also plunge nurses and doctors in public hospitals into even deeper despair.[55]

> 'The current government is decreasing the states role in financing health care and encouraging the private insurance sector to provide, so that ultimately the elderly's consumption of health care resources can be transferred to them as there numbers grow, relieving the government of the so called 'burden of the elderly' in the new millennium.'[56]

A National party conference confirmed that small hospitals are going to keep disappearing, but the possibility that very large hospitals will get smaller is more disturbing.[57] This offers private companies the opportunity to expand its services into the high-volume, low cost, high profit procedures which the public system have withdrawn from.[58]

What does the union of two right wing parties into a coalition government do for the health care of elderly in New Zealand? The 1997 Coalition Government budget declared that 'the Coalition Government is one that is dedicated to better health, and is making solid progress in reshaping the health sector.'[59] A fundamental change was to move from four regional health authorities to one central funding agency to be known as the transitional health authority, and to shift hospitals away from a focus on profit towards one of 'service in a business-like fashion.'[60] The Coalition Government has provided additional funding for health, by allocating an extra $300 million in 1997/98 and in each of the following two years. The extra resources are to be directed at

- elective surgery to reduce waiting lists,
- free doctor visits and pharmaceuticals for all children under six,
- better mental health services,
- improving services generally
- managing additional health needs.[61]

In addition to this $900 million, the government wants to provide a clear indication of future funding levels to enable health managers to plan. For this purpose, a further $180 million per year in the 1998 budget is allocated, increasing to $450 million in the 1999 Budget. The intention of this is to allow health managers to plan ahead on the basis of realistic expectations of future funding levels. From 1 October 1998, the Government will also remove income and

---

55 F.Ross, $300m for health but asset-testing end delayed, *The Dominion*, 27 June 1997.
56 Ross, *The Dominion*, 1997.
57 D. O'Connor, 'Fatally flawed' principles; CHE statement alarming reading, *The Nelson Mail*, 23 August 1997.
58 J. Anderton, Health already private, *Truth*, 18 April 1997.
59 The 1997 New Zealand Budget, p.148.
60 The 1997 New Zealand Budget, p.148.
61 The 1997 New Zealand Budget, p.148.

asset testing for long-stay public hospital care and asset testing for long-stay private hospital care for the elderly.[62]

At present, the following asset levels apply. Anything under these amounts will be subsidised by the government

- $6500 for single or widowed people or
- $13,000 in joint assets if you are a couple and both in long term residential care or
- $40,000 in joint assets if you are a couple and only 1 partner is in care
- You must contribute any income you get towards your care - up to $636 a week (this is the maximum contribution required per person, regardless of your income).

The assets taken into account include the following:

- Cash or savings
- investments, shares or stocks
- loans made to other people
- your house, chattels and care if you live alone
- gifts over the limit below made in the last 5 years

Assets that are not counted include the house, chattels or car if a partner or dependent child still lives at home, personal belongings such as clothing and jewellery, pre-paid funeral expenses up to $10,000. Income is considered money, irrespective of the source (New Zealand superannuation, veterans pension or income support, private pensions or pensions from an overseas government, contributions from relatives, ACC payments, earnings from investments or business are all included). The home is counted as an asset if the person is single, widowed, or both partners are in long term residential care. The home is not counted as an asset if there is a couple and only 1 partner is in care. If the home counts as an asset then eligibility for a subsidy is unlikely. However, an interest free loan may be sought from income support which then must be repaid if the person dies or sells the home.

As can be seen from the criteria, this nets a huge number of the elderly. These are people who have worked and paid taxes, accumulated assets for their enjoyment and necessity in later life, with the belief that their children will inherit what they have built up. For many elderly, to have it all striped away by the state when they become sick and in need care is an insulting way to be treated. The promise to abolish asset and income testing for long-term hospital care was welcomed, however, it is questionable whether the changes will reduce the hardship experienced by the elderly. Proposed changes promising the abandonment of asset and income testing for the elderly are not breaking down the economic drive of the health care reforms, but merely reversing an extremely unpopular policy. Furthermore, the actual effects of the legislation will be minimal. The Budget suggested income and asset testing for the elderly was to go from October next year. But the fine print spelt out that income and asset

---

[62]The 1997 New Zealand Budget, p.148.

testing would be abolished only for people in long-term public hospital care. Furthermore, considering that the government is dramatically reducing public beds and hospitals[63] making room for the private sector which is building hospitals to take over the government's role, this change in legislation will improve the situation for the few elderly who rely on the public system. Asset testing for people in long-term private hospital care was also abolished, however, they will still be income tested. All New Zealand's elderly will continue to be asset and income tested if they need resthome care. Only around 550 elderly are in long-term public hospital care while there are 5400 people in long-term private hospital care. Likewise only a handful of people are in public resthome care while the 21,000 residents in long-term private resthome care will continue to face both income and asset testing.[64] The Grey Power Federation has only belatedly realised that the good news in the Budget was far from what it was promoted to be. 'What that effectively means is that both income and asset testing for most elderly people is still firmly in place,' said Grey Power executive officer Marie Bayer. She said most people who needed care first went to a resthome, which provided a lower level of care than a hospital. Pert Bates said that at the moment about half of the people moving into residential care did not qualify for a subsidy and paid the full fees themselves, with the other half qualifying for a subsidy.[65] Based on this a couple would need around $1000-$1100 a week to pay for resthome care with many would be forced to sell their home to meet the bills. As they got older and more frail they would need long-term hospital care, and for most that would be in a private hospital. 'But at that stage many elderly would not have an asset left to test, they would have sold it to pay for resthome care,' Bayer said.[66] They might still have a modest income, even if it was only their super payout and the government would continue to demand that be directed towards meeting the cost of hospital care. 'The perception among many elderly has been that asset and income testing had gone for people in care. But that is not the reality.'[67]

The removal of income and asset testing for long-stay public hospital care and the removal of asset testing for long-stay private hospital care does not demonstrate that the current government has grown a conscience. Rather it is a way of suppressing a burning political issue and an attempt at maintaining an increasingly powerful grey vote for the next

---

63 Between 1984 and 1990, approximately 25 public hospitals were closed, mostly in rural areas, and against widespread community protest as cited in Health policies scrutiny urged by campaigner', *The Press*,30 July 1996, Newsnet 10.

64 G.Sheeran, 'Asset testing still a reality; Budget's 'good news' affects very few', *Sunday Star Times*, 6 July 1997.

65 Needs matched with best of care, *Waikato Times*, 29 August 1997.

66 Needs matched with best of care, *Waikato Times*,1997.

67 Needs matched with best of care, *Waikato Times*,1997.

elections. While removal of income and asset testing is set for the end of 1998 it is naive to assume that the underlying theory has been abandoned. Just what form such testing will mutate into is something to ponder.

It must also be questioned whether the proposals constitutive a fundamental change and, therefore, an implicit rejection of Nationals' health reforms, or just a disguise to make them more digestible. The Health Minister, Bill English, answers this somewhat cryptically as he is quoted as saying he will "dismantle *and* soften" National's health reforms.[68] It is hard to understand how both of these objectives can be achieved. It appears that changes are to be implemented in areas which have either been starved of public funding or have been tainted due to their lack of popularity. In critiquing the proposed changes the following observations are made. The major structural change proposed, of moving from four regional health authorities to one funding agency, shows quite clearly the lack of popularity and indeed failure of the original reform idea. The move to abolish the RHAs and return to a single central funding department to finance regional services on a population-based formula would end National's purchaser/provider split. A return to centralised funding is welcomed by the Nurses' Organisation and the Medical Association which says doctors want to work with a single agency as trying to deal with four different systems for no apparent good reason is a difficult task. The Medical Association went further to unequivocally state that they would indeed encourage a central funding agency taking over from the RHAs.[69]

The coalition government makes the claim that it will remove the profit motive from health. It would seem, however, that the deception in this is shown by announcements at the beginning of 1997 that Hamilton Doctors are building a multi-million dollar private hospital to compete with the area's CHE. Other similar contracts have recently been awarded out to private providers in other parts of New Zealand. For them, it is business as usual. The coalition agreement does not appear to be stopping this flow of public money into private providers' hands. Private providers are not philanthropists, they run businesses and the aim of all business is to make a profit. It is believed that if the coalition government meant what it said about removing the profit motive, it would end competition and the awarding of contracts to the private sector. It has not said it will do so.[70] There has been little reaction from doctors about the coalition's announcements. This is not surprising. While there are pockets of doctors who continue to oppose the health reforms, the trend has been for industry self-interest to prevail. Most New Zealand doctors are deeply compromised as advocates for the public health system. The tradition in New Zealand is for specialists to work in both the public and private sector. The majority of GPs have been entering contracts with RHAs which give them capitation or bulk funding for patients and allow them to keep the profits they can make if they

---

[68]KIWINET. *Sunday Star Times*, 12 Jan 1997
[69]Coney, 'Parliamentary Elections', 1996,p.34.
[70]KIWINET, *Sunday Star Times*, 1997, p.68.

under service them.[71] The CHEs were used because they offered lower prices than the private providers. The CHEs are able to operate on private patients under protocols drawn up by the Ministry of Health last year. However, under the coalition agreement between National and New Zealand First, private work undertaken by public hospitals must be limited and approved by the coalition partners.[72]

While additional funding for health in the budget is welcomed, it is hard to see past the fact that this is just a variation on National's crisis-inspired ad hoc cash injections. Such injections appear more as a necessary appeasement ploy, rather than achieving any real benefit to the health care system. The money is being injected into the most sensitive areas, those which are causing the most contention amongst citizens and Parliament, such as waiting lists, mental health, and child health care. It appears that proposals cover the bare minimum which needed addressing. Health care was a major issue of the 1996 election with political parties staking their reputation on fundamentally changing the system. Each party published manifestos as to the changes it was to make. Proposals ranged from the Alliance's 100 percent publicly funded health care system financed by those in the upper income bracket to National's status quo with a continuation of ad hoc cash injections in specific places. The Coalition Government's health care proposal outlined in the 1997 budget is New Zealand First initiated. The proposed reshaping of the health sector appears to be more of an appeasement plan to satisfy those who voted for the stand New Zealand First took on health care, than a substantial abandonment of the popular market reforms.

It would appear, based on the changes that have been made, that self-interest on behalf of the junior coalition partner was the main reason for any changes at all to health care. There seems to be two clear reasons for this. First, there was strong public pressure for changes to the controversial areas, namely mental health, asset testing for the elderly, and waiting lists. Those areas had received the most media coverage and were seen by the public as having been neglected by the public system. The second reason involved Winston Peters' need to retain a substantial grey vote come next election. The direction which the Coalition has embarked upon is far from a turning point for health care. New Zealand First made election promises it knew it needed to keep if it was ever to have a chance in the next election. It needed to gain credibility by fulfilling its promises, therefore, public health care was earmarked for much needed funding. But in reality the substance of changes made were superficial and unconvincing to the critics and those elderly in need of ongoing care.

The Coalition health policy defines its 'overriding goal' as 'ensuring principles of public service replace commercial profit objectives for all publicly provided health and disability services.' Former Associate Health Minister Neil Kirton is adamant that it was his adherence to that principle, and specifically his continued resistance to 'creeping privatisation',

---

[71]KIWINET, *Sunday Star Times*, 1997, p.68.

[72]N.Maling, 'Public hospitals to cater for private patients' , *The Evening Post*, 13 Dec 1996.

that led to his sacking in early August 1997. 'In vital policy areas, I was combating the vigorous attempts of (Health Minister) Bill English and various health officials to renege on the coalition agreement. Their agenda to privatise remains plain.'[73]

Conclusions

The goal of this chapter was to evaluate the validity of the questions being asked in regard to three fundamental changes. The first issue to be addressed related to what instigated the reforms and whether or not the reforms have been responsible for the rapid increase in private health insurance (PHI). If so, the objective was to discover in what way, and whether or not the justifications for the reforms stand up to critiquing. It was found that the instigation of the reforms emanated from two factors. First, the world wide drive for privatisation which was influenced by international bodies, the IMF and the World Bank. This has been especially influential when combined with policies of cost containment initiated by other countries, namely the United Kingdom. The second reason for the reforms may be attributed to the government's concern for rising social expenditure and the continuing economic slump. On this basis, reforms would be seen as a way of allowing the private sector to take more responsibility for health care costs. The facilities of the reforms could be seen in the supposed benefits, the improvements of management, more effective and efficient use of resources, clearer lines of accountability, and the idea of cost-containment.

The second issue discussed is the impact of the ideology of neo-liberalism becoming the corner stone for policy formulated on health care in New Zealand. Neo-liberalism appears to have been adopted as the New Right ideology from which all policy is to be based incorporating the market into the functioning of the social framework. National has used this ideology to disentangle itself from the state provision of public services, in particular health care, with publicly provided health care destined to become a welfare service; a safety net reserved for those in the lower socio-economic group. It is easy to see why a policy of redistribution of burden, from the government onto the individual, is advantageous given the burgeoning numbers, and consequently increasing health care cost, of the elderly in the next millennium.

Third, the Coalition Government made some necessary changes to the system which will see a lessening of hardship and despair for the elderly. The question was posed whether this injection of funding is a turning point for health care, or merely an act of appeasement by the Coalition Government. Evidence points to the latter being the case as evidence shows that the changes made are basic and critical ones, promised in the election manifesto - the government would not have got away with anything less. The cash injections are token

---

[73]Policy is to remove profit from public health, *The Dominion*, 9 August 1997.

appeasement to be injected into health care areas which were originally government funded before the reforms. This finding, although not conclusive, is also suggestive of the junior coalition partner's mindful view of gaining a substantial amount of support from the grey power vote in the 1999 election.

CHAPTER FOUR

Validation of the micro issues: Reality *for* the Elderly of Private Sector involvement in Health Care

This chapter will examine the impact of changes on the elderly as a result of the market being incorporated into health care. It is argued that the private sector, in particular insurance companies, while increasingly important providers of health care services have a number of fundamental deficiencies which are affecting the elderly now and are unlikely to improve in the future. The key questions that this chapter will address are what evidence is there of a continued policy push by the Coalition government to shift health care into the private sector and reduce the state's role in the provision of health care? How would such a shift be likely to affect the ability of the elderly to access the services? How does the shifting of funding sources impact on the problems of access for the elderly? Are rising premiums forcing many elderly to cancel or reduce the coverage of their policies?

The results of a survey answered by 230 elderly over the age of 65 confirm much of what has been hypothesised. The private sector perspective was obtained in interviews with the managers of leading insurance companies, Southern Cross and Unimed.[1] The purpose was to gauge the position of these companies and their opinion both as to the direction of the private insurance market and their increasing role as providers of health care. The feedback here generally expressed frustration and uncertainty about government decisions coupled with concern over having to increase premiums.

> 'a clear, long term vision and direction for the health sector - is still lacking. Until this direction is set by the government and understood by health providers, New Zealand may not see the commitment to innovation that its health sector needs'[2]

---

[1] The managers of eight other insurance companies declined the opportunity to comment.
[2] G.Sheeran, 'Private health costs sure to rise', *Sunday Star Times* 1June 1997.

The Continuing shift into the private sector

What evidence is there that the coalition government will continue to propel health care into the private sector and effectively reduce the state's role in the provision of health care? Continuous cutbacks in public sector spending, as shown in chapter 2, reveal that the government's premeditated withdrawal from the health care arena is not a recent trend but has been a continuous long term withdrawal. As Health economist Dr Pim Borren commented, there has been a huge shift from public to private health expenditure taking place with no consensus about what was the proper level of public health funding.[3]

> 'Before the last election, there was a lot of talk about more money being put into the public health sector, but we have seen little evidence and I think there is some disappointment out there...'[4]

'The Coalition government is committed to travelling the path of privatisation for health care' stated Jim Bolger the then National party leader and Prime Minister in the middle of 1997.[5] The government's message after the 1996 election was clear - there was to be a continuation of the private sectors role in health care and, at the same time the so called 'nonsense' over private sector involvement in health was to end.[6] Bolger stated:

> '...it is time to confront the reality that better integration of the public and private sectors would provide better health care. We must stop the nonsense that seeks to portray public health care as good and private health care as wrong, .Only when we confront the reality of the benefits of integrated health care will we, the community, get the best possible care.'[7]

Bolger shows here that he is committed to incorporating the two sectors. The result, he contends, is the provision of better health care for the community. Exactly what is meant by 'Only when we confront the reality of the benefits of integrated health care will we, the community, get the best possible care' is obscure. Considering the agenda of Treasury is to reduce spending in all social areas, Bolger can only be referring to the trickle down effects of running a budget surplus and achieving a favourable economic position by slashing social spending and incorporating the markets.

---

[3] G.Sheeran, 'Private health costs sure to rise', *Sunday Star Times* 1June 1997.
[4] Sheeran, 'Private health costs sure to rise', 1997.
[5] Prime Minister Jim Bolger stated in a speech in Manukau on the 8th of October 1997, as cited in The Dominion, 'Government moves to wrest back initiative on health issues', 9 Oct 1997,p.2.
[6] Prime Ministers, speech, 1997.
[7] Prime Ministers, speech, 1997.

A Health Ministry report *'Health Expenditure Trends in New Zealand 1980-1996'* shows the movement toward the privatisation of the public health system was active from the 1980s.

The increasing proportion of Private Health funding

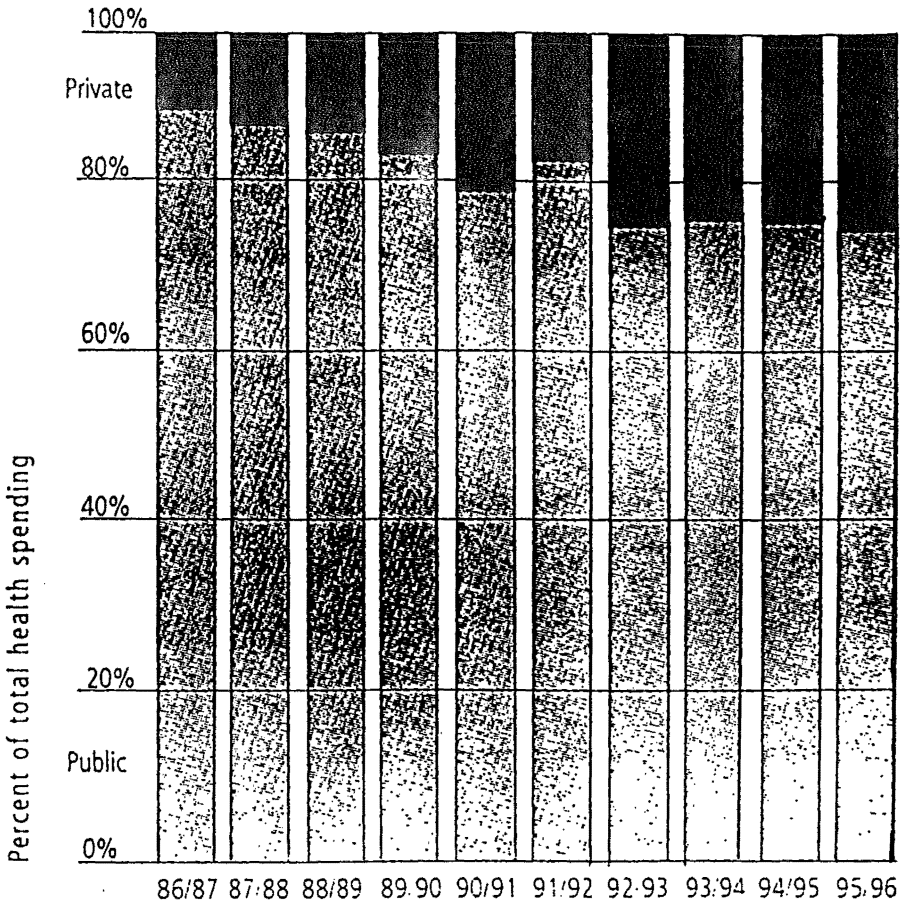

Figure 9 *Source*: Health Expenditure Trends in New Zealand, Note Private Health Funding Comprises private insurance and other sources.

Figure 9 denotes the increasing proportion of private health funding while conversely showing the steady decline of public health funding. The Health Ministry Report confirms a continuation of shifting the provision of publicly funded health services from public hospitals to private ones.[8]

> 'If public understanding of what the tax dollar will provide is not enhanced and the cost shifting driven by the increased demand for acute services in the public sector continues at the current pace, then the burden of the shift for elective surgery falls on the currently insured market. It already has'[9]

---

[8] Powell 'Public Health Privatisaion trend conern'. *The Dominion*. 21 May 1997.
[9] Roger Bowie, CEO, Speaking at the Annual General meeting, as cited in Southern Corss Annual Report 1997.

While the National Party's agenda involves privatisation, New Zealand First stated in its pre-election manifesto that it was opposed to privatisation of the health care sector. Yet the coalition agreement appears to have forced a change of heart with New Zealand First adopting National's position wholeheartedly. When Associate Minister of Health Neil Curtain opposed the Minister of Health's determined privatisation push, he was removed from his position by the leader of the junior coalition partner. This was a clear demonstration of the coalition government's intention to follow the privatisation path as laid down by National with as little interference as possible. The new Prime Minister Jenny Shipley appears to be as ideologically neo-liberal as her predecessor, if not more so. Her record in the Health and Social Welfare portfolios suggest that she will follow the lines of Bolger, if not even more aggressively, having already stated publicly that there is to be a continuation of the current coalition policy.[10]

Impact of Privatisation Push

The government has forced people onto private providers by reducing public funding across the board and ultimately diminishing the size of the protective public health care umbrella. For example, in 1985 around 12 percent of health care was funded by the individual and 88 percent by the government. Now, in 1997 the government picked up only 76 percent of the bill, with individuals paying for 24 percent (see chapter 2).

> 'Part of the plot in health is to run down the public sector so people feel they have to go private, as the public sector gets run down there is more of a case for the involvement of the private sector.'[11]

An 80-year old a war widow from Palmerston North suffering from a brain tumour was admitted to Palmerston North Hospital for four weeks of radium treatment. When the treatment was finished the family was told the women would have to leave as there were 'no more funds available' on the woman's file. When the family asked if the woman could be transferred to one of the geriatric wards, they were told these wards were not taking anyone. 'The staff said they were sorry but she would have to go.'[12] The patient needed nursing care as she is incontinent, could not walk or get out of bed by herself and has memory problems. Hospital staff were sympathetic with one urging a family member to 'make some noise' about it as she was tired of having to turn people away.[13] This case is indicative of the macro health

---

[10] This was announced by Winston Peters on Television 3 on the 6pm News, November 4 1997. Further in a press conference after taking the oath of office on the 8th of December 1997 Mrs Shipley stated that Welfare reforms would be back on the agenda 'with a new emphasis on soical policy' stating further that 'The question is: are we bold and brave enough to address the social policy questions that are still before us?' The Press 9th December 1997, by Michael Rentoul

[11] K. Batchelor, 'Health for the rich only: Coney', *The Daily News*, 10 October 1997.

[12] R. Forde, 'No bed for dying war widow', *The Evening Standard*, 4 Oct 1997.

[13] Ibid.

management structure that has been adopted. In response to criticism attracted over their action MidCentral Health medical and surgical services manager Anne Aitcheson stated that;

> 'Palmerston North Hospital was not funded [by government] to provide continuing care for the elderly, which was why it could no longer accommodate the woman after her cancer treatment had finished.'[14]

With the hospitals unable to provide continuing care, elderly needing long-term nursing must be placed elsewhere for their needs to be met. Aitcheson stated that fewer public hospitals were in a position to offer continuing care as regional health authorities had tended to award such contracts to private providers such as rest homes. A private hospital in Manawatu would cost $1100-$1200 a week to look after a patient such as the widow. Similarly a place in a private hospital in Taupo costs $637 a week.[15]

> As a result of a reduction in public spending, private health schemes have developed to fill the void. 'While funding for public health services is still below the levels of spending in the late 1980s, private has almost doubled since then, Nearly a quarter of total health spending is now from private sources.' [16]

1.3 million people now spend in excess of $400 million annually for such protection. Fundamentally, when the private sector controls areas of health delivery and provision, the criteria for entry become economic and this creates major distributional concerns. Services which were once part of the public sector are being dropped as willing entrepreneurs in the private sector take advantage of inelastic demand for essential life preserving services. Private companies are reaping the benefits of performing high-volume, low-cost, high profit procedures while the cost of the same procedures in the public system rises. Far from reducing the cost pressure on the public system, private involvement is likely to intensify it.[17] As the Health minister commented;

> 'private insurers had not been as effective at controlling costs as the old public sector. Prices in the private market are significantly above prices that are paid in public.'[18]

In October 1997 the Health Minister announced that they would be reversing the CHEs profit making agenda. The Minister affirmed that the profit motive had failed in health.[19] This

---

[14]R. Forde, 'No bed for dying war widow', *The Evening Standard*, 4 Oct 1997.
[15]Forde, 'No bed for dying war widow', 1997.
[16]Ian Powell, Association of Salaried Medical Specialists executive director was refferig to stats in the Health Expenditure Trends in New Zealand 1980-1996 in 'Public Health Privatisaion trend conern', *The Dominion*, 21 May 1997, p.8.
[17]J. Anderton, 'Health already private', *The Truth*, 18 April 1997.
[18] J.Kirk, 'Eye surgeons investigated', *The Press*, 6 March 1997
[19] As stated by the minister of health in response to a question by M.Hoskings on *BREAKFAST* show, 22 October 1997.

illustrates to a degree the experimental and naive nature of the policy decisions made by government. This erosion of the public health system feeds concern over access to public health facilities. Public concern is now so great that a third of the population is covered by some form of private health insurance.[20] The process of withdrawing public financing from health care is generating great anxiety amongst the elderly, so much so that 50 percent of those surveyed place this as their greatest concern ahead of waiting lists. Figure 10 shows the findings.

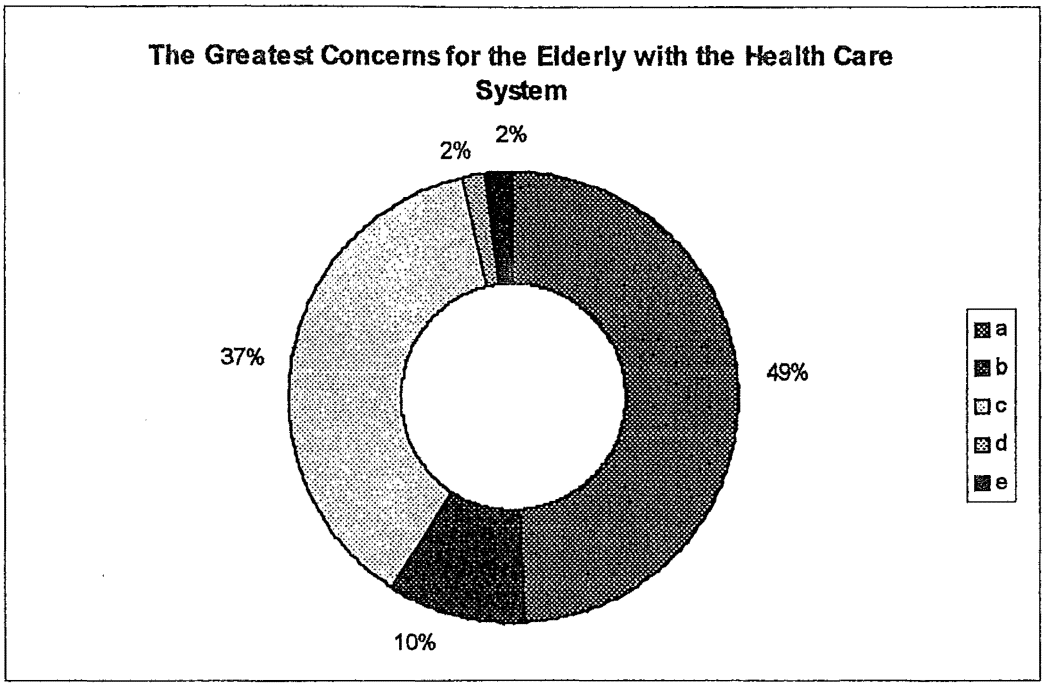

Figure 10 ***Source*****: Health Care Survey of the Elderly 1997**

Legend:
Those which are of the greatest concern to the elderly:
a. (49%) the reduction in public funding in health care
b. (37%) waiting lists
c. (10%) rise of private involvement in health care namely private insurance markets
d. (2%) other concerns
e. (2%) nothing is of concern in the health care system.

The elderly are perceptive of changes occurring in the health system and the consequential diminishing of the government's social responsibility. The changes have created

---

[20] Anderton, 'Health already private', 1997,p.17.

a feeling of vulnerability. Government withdrawal of financial support means both physical and financial uncertainty for the elderly as concern over accessibility of treatment and an ability to pay for it increases. These are issues of life and death for an elderly population which is very aware of the importance and impact of changing public policy. They are not blessed with decades of working life to prepare for economic outlays in their budgets, a fact which leaves many with imposing uncertainty. Figure 9 reveals the results of a survey question asking the elderly about their concern with their ability or inability to access adequate health care services.

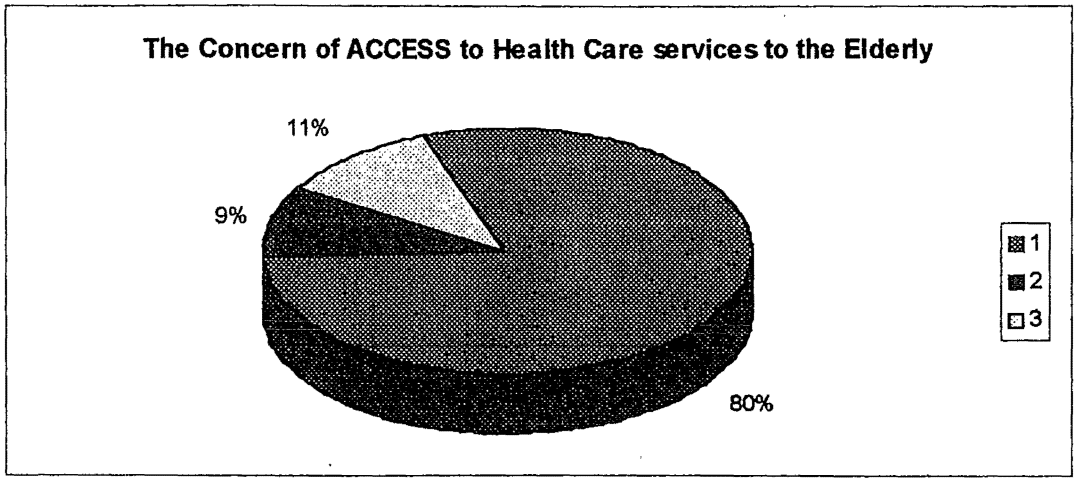

Figure 11 *Source*: **Health Care Survey of the Elderly 1997**

Legend:
1. 80% are those elderly who say that access to health care services is a concern for them.
2. 9% are elderly who have no access concerns whatsoever
3. 11% are those elderly which have private health insurance and are not currently concerned.

The reduction in public funding is causing grave concern for the elderly who have limited financial resources to allocate to their health care. Public concern is also evident. 33.2 percent of voters pinpointed health services as 'the most important issue in the country at the moment.' This was 5 percent higher that any other concern.[21]

Shifting the Health Providers and Creating Access Issues

Ron Dowdall has spent his mother's $90,000 savings in two and a half years to keep her in a tiny resthome cubicle. A large chunk of the $200,000 his 87 year old mother, Connie, inherited from her brother will be taken by the Government under the asset testing policy on

[21]New Zealand Hearald Opinion poll, New Zealand News *Teletext*, 18 Oct 1997.

elderly people which remains in place in private rest homes despite being abandoned in both public and private hospital care. Ron worked hard helping his parents develop properties and was always told he would one day be rewarded with an inheritance. 'But now I've paid out $90,000 and I can see the family asset being stripped away.' It costs $951.72 a week for his mother to be kept in a private rest home, with her paying $636 and the rest topped up by the Government. Mr Dowdall said the policy has detrimental effects.

> 'It makes everybody conscious of grabbing what they can, when they can. There were no holidays or new cars, there was a family sacrifice to get that asset. Asset stripping encouraged families to waste their money because there was no point in working for an asset. My father would be turning in his grave with this sort of situation. After the war they worked hard to save, now a lifetime's savings will be gone in three years.'[22]

Around 550 elderly are in long-term public hospital care and their presence is really a carry-over from the days when public hospitals provided that sort of service. There are 5400 people in long-term private hospital care. Similarly, only a handful of people are in public rest home care while 21,000 residents are currently in long-term private rest home care, and will continue to face both income and asset testing.[23] In the 1997 budget the Coalition Government announced it would abolish asset and income testing for long-term hospital care from October 1998. However, this applies to private and public hospital care only, the tests will still apply to residential resthome care. Currently about half of the people moving into residential care did not qualify for a subsidy and paid the full fees themselves (around $600 plus per week).[24]

> 'What that effectively means is that both income and asset testing for most elderly people is still firmly in place.'[25]

Most people who need care would first go to a resthome which provides a lower level of care than a hospital. A couple would need around $1000-$1100 a week to fund the care and many would be forced to sell their home to meet the bills. As they get older and more frail long-term hospital care becomes necessary and for most a private hospital is the only option.[26] The reality is, however, that many elderly would not have an asset left to test as everything would have been sold it to pay for resthome care.'[27]

---

[22] G.Bailey, 'Too late to save mum's nest egg', *The Evening Post*, 27 June 1997.
[23] Sheeran, *Sunday Star Times*, 1997.
[24] According to Petra Bates as stated in 'Needs matched with best of care', *Waikato Times*, 29 August 1997.
[25] Grey Power executive officer Marie Bayer as cited in G.Sheeran, 'Asset testing still a reality; Budget's 'good news' affects very few', *Sunday Star Times*, 6 July 1997.
[26] Bayer, as cited in G.Sheeran, 'Asset testing still a reality; Budget's 'good news' affects very few, 1997.
[27] Sheeran, 'Asset testing still a reality,1997.

Over enthusiasm by private entrepreneurs has raised concern by funding agencies that growth in residential care for the elderly has leapt ahead of population growth and threatens to take funding away from other people with disabilities. Midland Health stated in mid 1997 that it would put a cap on funding Taranaki's rest homes and private hospitals. This followed an announcement in early 1997 that the demand for home care had caused funding to jump from an initial $2.5 million to $16 million in two years. Even Midland's view that elderly people would rather live in their own homes than in institutions did not prepare the funding authority for such sky-rocketing demand and a tightening of criteria was announced in January. Midland stated that the demand for home care is keeping people out of rest homes for longer, which means the age of admission is becoming higher and the required standard of care more expensive.[28] Figure 10 shows the elderly's opinion of rest home expense and what impact it has on their use.

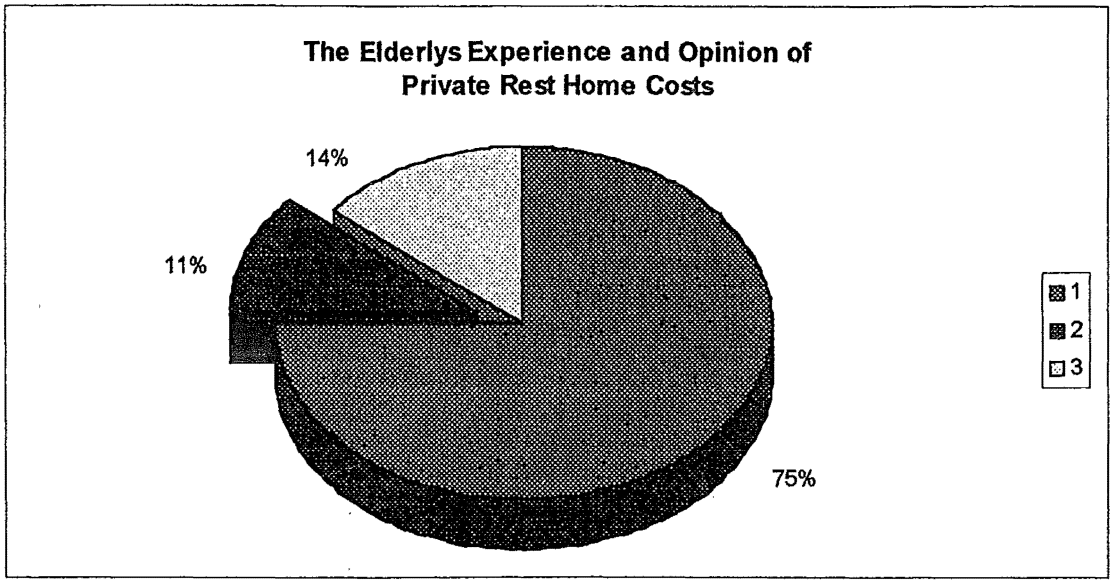

Figure 11 ***Source*****: Health Care Survey of the Elderly 1997**

Legend:
1. 75 percent are those elderly who in there experience thinks that the cost of staying in a rest home is an impediment to actually using the care
2. 11 percent of elderly believe that the cost of private rest home care is not an impediment to using the care
3. 14 percent of those elderly surveyed were not sure about the issue.

As one elderly person commented:

---

[28]'RHA to explain fears over cost of growth in old folks'homes', *The Daily News*, 14 August 1997.

> 'I think an inquiry should be made as to why it costs $500-600 per week in a home to keep one person, when none of these people live in their own homes costing this much'[29]

Policies relating to the elderly, such as the income and asset testing are apparently designed to keep them in the community for as long as possible. Asset and income testing results in the elderly remaining in their own homes for longer out of fear from losing them or due to family concerns over the thought of their inheritance eroding. A number of wider implications result from such policies. The domination of the private sector of rest home market and the high costs of being put in resthome care for the elderly combined with government asset and income testing have caused greater numbers of elderly to stay by themselves or in their family's care for longer. Effectively there is then a transfer of responsibility to the families which in turn takes the cost off the government. As the burden is transferred onto the caregivers, usually family members, frantic efforts to juggle work and family commitments creates great stress in the home and workplace.[30] Both parents work in more than 50 percent of households and in 27 percent of families (over 165,000 families) there is just one parent. Three years ago 12 percent of unemployed women and 3 percent of men had left jobs because of family responsibilities. Many parents are caught in the double squeeze of having children late in life and also having to care for elderly parents.[31] This all adds up to greater stress on families and an alarming number of elderly abuse cases.

A nation-wide service investigates 500 complaints of abuse against the elderly each year with Age Concern setting up seven pilot schemes in the past four years to combat the growing problem of elderly abuse and neglect. The departments of Police, Social Welfare and Health have identified elderly abuse as a key area needing attention. New South Wales research suggests that about 2% of older people are victims of either abuse or neglect. In terms of New Zealand's senior citizens that is 8700 cases. Other international studies report rates as high as 3% to 5%. So far, elderly abuse teams working twenty hours a weeks have detected 1 percent of the population.

> 'It's quite possible within the next two years we will get to 3-5 percent. It's unfortunate if we do, but our research mimics that done overseas. We are falling into a pattern here, so we have no doubt that we have a similar incidence of abuse.'[32]

The latest figures released by Age Concern show that its seven teams deal with around 495 referrals from friends, families, health professionals and other agencies each year. Of those, 80

---

[29]Comment made in the HC 1997 by an elderly person, refer Appendix C.
[30] M.Henderson, 'Employer help with juggling act is vital', *Sunday Star Times*, 13 July 1997.
[31]Henderson, 'Employer help with juggling act is vital',1997.
[32]This observation was made by the national director of Age Concern Deborah Moran

percent are confirmed as cases of abuse and neglect. The overwhelming majority of clients (71 percent) are women over 65.

> 'What horrifies me most is the range of abuse people have been putting up with for a long time. In 41 percent of cases, the abuse has been going on for more than a year and that's really significant. In most cases, the abusers are the son or daughter of the client (43 percent), compared to 14 percent involving partners and 23 percent involving primary caregivers. In the cases where the son or daughter is the abuser, the older people do not want to go to the police or take legal action against their own children, but they will go to a community agency like Age Concern'[33]

The most common type of abuse is psychological (39 percent), followed by financial (30 percent), physical (11 percent) and sexual (0.5 percent). But 72 percent of referrals report multiple incidents of abuse and neglect features in 19 percent of all cases. While elderly abuse does occur in rest homes, 32 percent of abuse victims live alone and 24 percent with their families. It is the elderly in this latter category who were more likely to suffer multiple types of abuse. There is a concern that as the reluctance to enter private rest homes grows this scenario will increase.[34]

Teams spend significant amounts of time dealing with cases of self-neglect reported to them. A national advisory group consisting of Age Concern, the police, the Ministry of Health among others, has monitored the elderly abuse programmes for the past two years. There are 22 assessment, treatment and rehabilitation units throughout New Zealand.[35] The purpose-built, multi-disciplinary unit known as the Assessment and Rehabilitation Unit for the Elderly at Taranaki Base Hospital is about to be dismantled and beds cut. The Day Ward is no longer going to exist.

How is this going to affect the elderly in the community? At present, services for the elderly are superior. Representatives say many of the patients are at home, independent and maintaining their dignity.

> 'I cannot understand why the managers are dismantling this unit, and, although I am told that there will be services available, I cannot understand why they are pulling to bits the most efficiently run service in the hospital.'[36]

Dr Taylor has striven over the last few years to build up a geriatric service that is envied by units up and down New Zealand. 'I am quite disheartened by the changes I am seeing and I do worry about my elderly patients and their future.'[37] Professionals from a number of different

---

[33]Henderson, 'Employer help with juggling act is vital',1997.

[34]Y.Martin, 'Elderly could lose abuse relief scheme', *Sunday Star Times*, 11 May 1997.

[35] Martin, 'Elderly could lose abuse relief scheme', *Sunday Star Times*, 11 May 1997.

[36] Dr Lorraine Taylor developer of the multi-discilinary Assessment and Rehabilitation Unit at Taranaki Base Hospital.

[37]'Why change unit which is running smoothly?', *The Daily News*, 5 August 1997.

areas in the caring process of the elderly are very apprehensive as to the impact reduced public funding is having on the elderly. The concern is that as greater numbers of elderly are forced to stay on their own, their physical safety will be compromised and the pressure on family members to care for them increased. These repercussions are a formula for neglect.

Fundamental Access Problems for the Elderly

Are rising premiums forcing many elderly to cancel or reduce the coverage of their policies? This is part of a broader question of access for the elderly. Fifteen years ago more than half of all New Zealanders held health insurance. That has now fallen to 40 percent. The cost of the cover is rising sharply with the major insurer Southern Cross putting premiums up an average of 12 percent per year. The company says that this is reflective of diminishing government input into the health sector.[38] Given this trend it is clear fewer people feel they are able to afford private health insurance at a time when public resources are being stretched further and further.[39] The public sector is struggling to manage increasing levels of acute hospital admissions leading the Government to suggest a cut in elective treatments. However, if fewer elderly people can afford private health insurance, sooner or later a large percentage of this growing group will have little or no access to elective hospital treatments such as hip or knee replacements, glue ear or cataracts.[40] The private sector is pricing itself off the market with massively rising insurance costs. This creating longer waiting times for hospital care and increases the pressure on the public system.[41] In 1990, before the reforms, there were 60,000 people on waiting lists. In 1997, that number had risen to 97,000 people; that is 1 in every 38 New Zealanders.[42] Moreover, in 1997, 20,000 people were reported to have been on waiting lists for more than 2 years.

> 'There is nothing efficient in long waiting lists, the procedure eventually costs the same or more. A person who waited for over two years before being treated for a heart problem estimated the delay cost him and the Government more than $200,000. Had the operation been done as soon as needed it would have cost $5000. So there's huge wastage in the delay particularly if a person is unable to work.'[43]

One of the arguments for implementing the reforms was that it would reduce the waiting times as a result of extra efficiency. This has failed. The public system is not providing an improved

---

[38] 'Health's catch-22 dilemma', *The Timaru Herald*, 13 Aug 1996.

[39] Dr Pim Borren as cited in M. Inge, 'Elective surgery access restricted to wealthy', *New Zealand Doctor*, Business, Sept. 1997.

[40] M. Inge, 'Elective surgery access restricted to wealthy', New Zealand Doctor, 1996.

[41] Graham Edmand, Chief Executive of Auckland Health Care in *FRASER* by Ian Fraser, TVNZ, Channel 1, 7 Oct 1997.

[42] Channel 3 News John Campell, 21 Oct 1997.

[43] Inge, 'Elective surgery access restricted to wealthy', 1996,p.40.

ease of access to quality services.[44] A tension exists between a fixed level of financial resources available for public hospital care on the one hand and a demand that greatly exceeds this fiscal cap on the other. Acutely ill patients are able to gain immediate access to the public hospital system but, once admitted, many will be subjected to long waiting times. A similar fate awaits those seeking elective services. In both the high-profile waiting-list surgery and the equally important but lower profile medical and diagnostic procedures, patients find themselves waiting inappropriately long and potentially unsafe periods of time for their surgical, medical or diagnostic procedures. In a number of North Island hospitals, for example, doctors are complaining that there are up to 16 week delays between diagnosis and treatment of cancer.[45] These waiting times are mainly a result of rationing due to a fiscal cap on public hospital expenditure, rising demand for emergency and acute services (naturally accorded clinical priority) and sub-optimal levels of productivity in the public hospital sector. No public relations campaign promising additional surgical and medical interventions will convince the individuals and families who require services that the system has improved unless they are given more timely access to waiting list surgery.[46]

Complaints regarding waiting lists for surgery are on the increase with many coming from people unable to get treatment because they do not have health insurance.[47] The government established a Waiting Times Fund dedicated to clearing waiting list backlogs. To date $130 million has gone into the fund with more offered in the budget. This money according to those who run the hospitals is not nearly enough and is spread extremely thinly. It is difficult to imagine that this is anything more than token appeasement fund, given that what is required is more substantial and consistent than what was given. Over the last three years health funding 'has been characterised by frequent ad hoc injections.'[48] These injections have been sprinkled on political hot spots when problems in health care arose due to cuts imposed from the reforms.

The latest proposal from the Minister of Health involves a Booking System. This is designed to alleviate the waiting list problem, not by providing more money but rather by implementing a process which assesses the eligibility of a person to have treatment paid for in the public system. The justification for the new system is that many people who are on existing waiting lists do not need to be there, a rather bizarre theory suggesting that people are wilfully undertaking unnecessary surgery. It is likely that the reference here is to those who do not require acute surgery and may, if adequately concerned, seek solace in the private sector. With 97000 people on waiting lists and an admission from the Minister that as many as 1/3 to

---

44 As shown in the survey of the Elderly 1997.
45 Channel 3, John Campell, 21 Oct 1997, interview with Health Minister Bill English
46 L. Levy, 'Throwing money at hospitals won't cure their ills', The National Business Review, Feb. 21 1997.
47 'Surgery wait lists 'increased 39%', *The Dominion*, 5 Aug 1996, p.3.
48 'Surgery wait lists 'increased 39%', *The Dominion*, 5 Aug 1996,p.3.

1/2 of those currently on waiting lists will no longer qualifying for treatment,[49] Graham Edmand, Chief Executive of Auckland Health Care, points out that significant numbers will be denied access through this new system. The criteria for qualification will become extreme need, he states, with the ultimate impact of the booking system being that many people will miss out on necessary health care services altogether.[50]

Mrs Kennard[51] went for her annual check up in order to renew her drivers licence. The medical examiner found she had developed a cataract on her left eye and had to have it removed before the licence could be re-issued. If she was to have the operation through the public system there would be a eighteen month to two year waiting list to see the specialist and then a nine to twelve month wait for the operation. Meanwhile she would not be able to drive. If, however, she chose to go private and pay for it out of her own pocket (she was not covered by medical insurance), she could see a specialist in 2-3 days, have the 20 minute operation within one week and be driving soon after - the cost $3000 dollars. Iris took the latter option. Now she has a cataract on the other eye. Mrs Kennard's story is not an uncommon one in New Zealand. Long waiting periods, reduced funding and the general ineffectiveness of the public health system makes it impractical for people to wait, so out of necessity they pay. This is in accordance with the user pays policy thrust of the government.

There is widespread concern about demands for hospitals to live within budgets. The bottom line is that people do not want fixed spending on health care[52] and from public feedback it appears they do not mind paying for it through their tax. A survey question asking the elderly what method of payment for health care was preferred revealed the following.

---

[49] Minister of Health Bill English quoted in *FRASER* by Ian Fraser, TVNZ, Channel 1, 7 Oct 1997. In order to qualify, the customer must be in an acute state.

[50] Graham Edmand, Chief Executive of Auckland Health Care in FRASER by Ian Fraser, TVNZ, Channel 1, 7 Oct 1997.

[51] Interview with Mrs Kennard, 10 June 1997, at 64 Hansons Lane, Upper Riccarton, Christchurch.

[52] Inge, 'Elective surgery access restricted to wealthy', 1996,p.42.

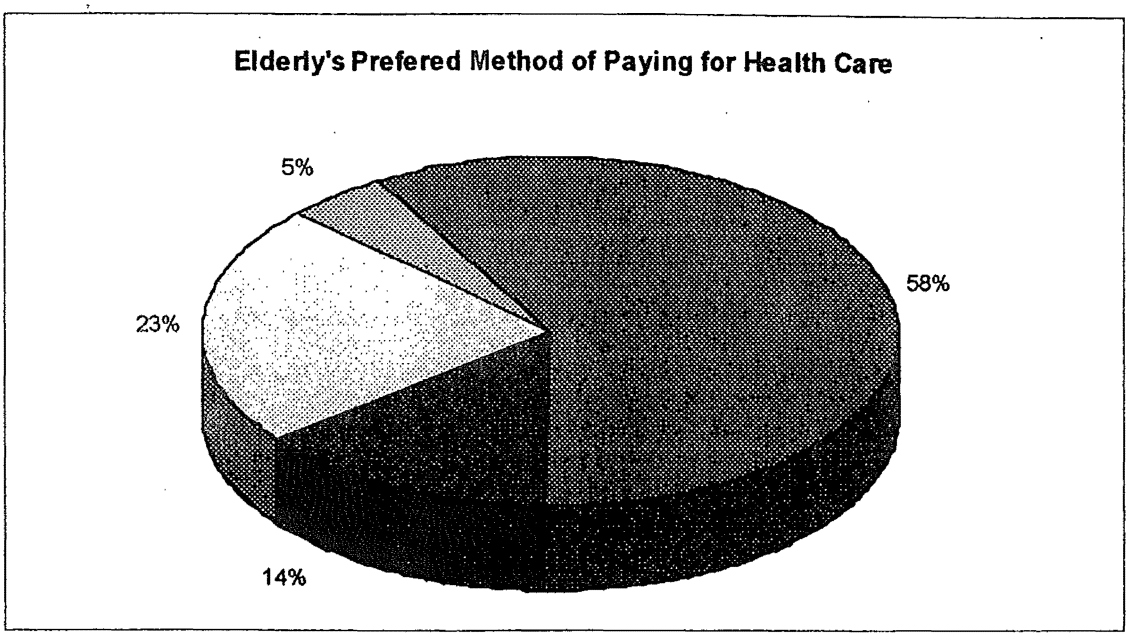

Figure 13 ***Source*****: Health Care Survey of the Elderly 1997**

Legend:
58% are those elderly in favour of paying for health care through taxation.
14% segment is for those in favour of paying through health insurance premiums.
23% are those in favour of paying for health care directly as needed (out of your own pocket). 6% are those that favour of all the above ways of paying for health care.

Nearly 60 percent of those elderly surveyed said that their preferred way of financing health care was through taxation. This could be interpreted as an endorsement of the old social policy with proponents wanting a 'free ride' on the system, especially considering that the elderly do not contribute to the tax take instead receiving government retirement income in various forms.

> 'I would gladly pay higher taxes and have no private health insurance in order to have public health care.'[53]

However, in a Colnar Brunton Poll it was found that 67 percent of the general population agree with the rejection of tax cuts, preferring that the money be put into health care and education.[54] This at least must signal the importance that the public in general and not just the elderly place on an health care system which is centrally funded.

---

[53] Comment from the HC survey 1997 by an elderly person, refer Appendix C.
[54] Data from One Network News Colnar Brunton Poll, as cited on *BREAKFAST*, 21 Oct 1997.

Private health insurance - the necessity, the expense!

'The only way to get equality of access in health care provision is to ban private health insurance - and that is not going to happen' ~ Bill English[55]

What can this case study tell us about the effectiveness of the PIM in providing health care effectively to the elderly on a micro level? The case study reveals a number of substantial inadequacies in the effectiveness of Private Insurance Markets in providing adequate health care effectively to the elderly. The first major problem concerns the financial accountability of insurance companies whose premium rates skyrocket uncontrollably. As earlier stated the major insurer Southern Cross is putting premiums up an average of 12 percent per year.[56] Fixed incomes of the elderly do not provide the flexibility needed to enable the over 65 group to adapt to these changes. Those who can afford the premiums are a diminishing group based in the middle to higher socio-economic group. In 1988 a family of four paid $404 for Southern Cross's Regularcare policy. In 1997 the same family now pays $1336. That's a rise of 230 percent during a period when inflation was only around 30 percent.[57] Older people have been hardest hit. In 1988, an older couple paid $432 for Regularcare. In 1997 it was up to $2140, that is an increase of nearly 400 percent. Southern Cross is not alone, premiums have been rising rapidly across the board. One reason for this is the increasing cost of claims. This has been caused by a variety of factors itself, including an ageing population and advances in medical technology. But primarily it is the transfer of elective surgery from the public domain into the private which has been the dominant contributor. The general manager of Southern Cross, stated that premium rises reflected what was happening in the health market. 'One of the key drivers is the fact people are having to use the private sector.'[58] The number of operations being performed in the public system has dramatically declined. Southern Cross is this country's largest private medical insurer with over 900,000 members. It claims that it now funds more elective surgery than the government. Latest official annual figures available show 143,626 elective procedures carried out in private hospitals compared with only 81,040 in public.[59] A second reason is the inclusion of new insurers who set premium prices at an averaged rate (undercutting existing insurers). This means that the old process of 'community rating' where by the young policy holders subsidise the older ones is no longer effective as new insurers are targeting these young groups and offering lower cost premium cover.

---

[55] Bill English was asked a question in an interview with John Campell on 3 Network News, 21 October 1997 by D.Galler; 'Do you believe in equality of access to HC provision for all New Zealanders?' the Health Minister Bill English replied with the above answer.
[56] Inge, 'Elective surgery access restricted to wealthy', 1996,p.38.
[57] B. Holloway, 'Health Insurer raises premiums', *Waikato Times*, 26 May 1997.
[58] Holloway, 'Health Insurer raises premiums',1997.
[59] H.LeGrice, Chairman of Sourthern Cross, statisitics from there annual report 1997.

Media reports suggest that thousands of retired New Zealanders are surrendering their private medical insurance once they turn 65 because their premiums have doubled.[60] Many elderly who have had insurance for many years have been forced to quit their policies due to skyrocketing premium increases. Figure 12 shows the number of elderly surveyed who are and are not covered by insurance and who have since cancelled it.

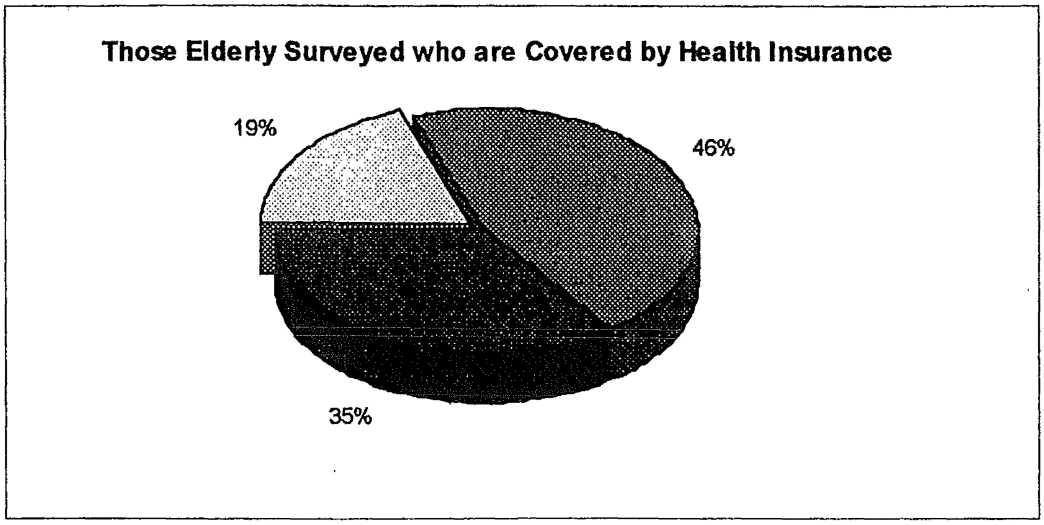

Figure 14 *Source*: Health Care Survey of the Elderly 1997

Legend:
46% are those who do not have private health insurance
35% are those elderly who do have insurance
19% are those elderly who have had insurance but have since cancelled it.

Figure 14 shows the duration of policies held by the elderly before cancellation. 40 percent who had cancelled their insurance premiums had in fact held them for 20 or more years. 20 percent paid premiums for 15 years.

60 Sheeran, 'Asset testing still a reality,1997.

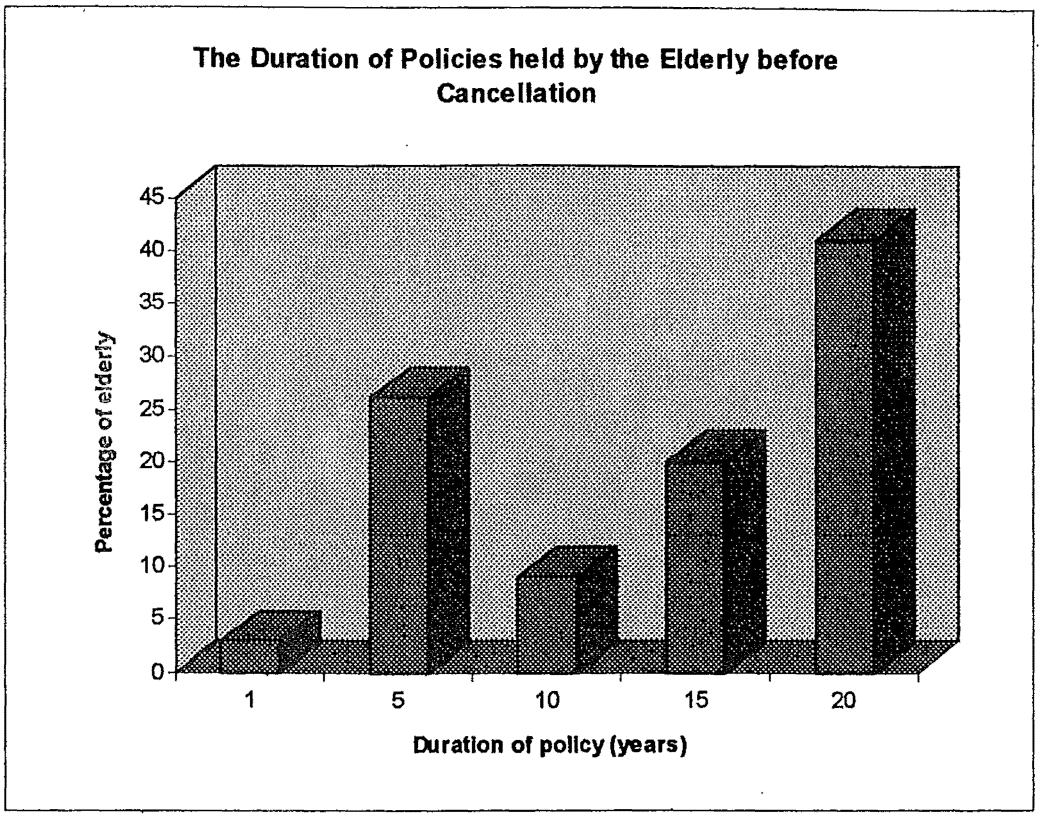

Figure 15 ***Source*****: Health Care Survey of the Elderly 1997**

The point is that the majority of the elderly who cancelled their policies had been long standing premium payers. They paid premiums for the past two decades, when they were younger, healthier and working. Now when they are older, retired and more in need of health insurance they are forced to cancel and take the risk.

> 'When the premiums rise, those who have not used their insurance tend to be the ones to cancel their policies. When Unimed announces that it will be putting premiums up on the 1 October 1997 by 10 percent, you can bet there will be a stack of resignation letters on my desk the next week, half of those people would not have put a claim in, in the last few years. The people who will keep their policies are the wealthy and the very sick as they need it - this results ultimately in adverse selection occurring.'[61]

The numbers of people abandoning private health cover has steadied after some big drops in the early nineties when health reforms were first introduced and the premiums on some policies doubled overnight.[62] 50 percent of the population had some form of private insurance cover in 1991 but that figure has dropped to 41 percent in 1997 as a quarter of a million people quit their policies. Southern Cross 'sensed' it was now around 40 percent.[63] The potential for

---

61 Interview with Dermott Martin, 1997.

62 Sheeran, 'Asset testing still a reality,1997,p.2.

63 As commented by David Turner, general manager of Southern Cross, in Sheeran'Asset testing still a reality, 1997.

disaster that this trend carries is demonstrated when one considers that the elderly, more than any other group within society, are heavily reliant on their medical insurance.

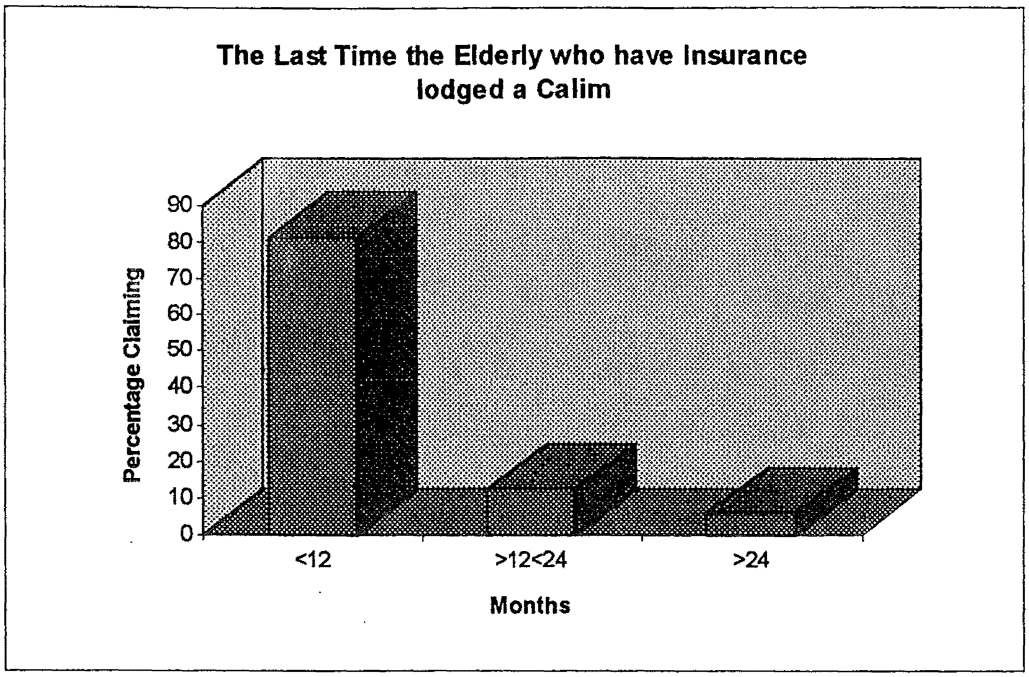

Figure 16 ***Source*****: Health Care Survey of the Elderly 1997**

While insurance companies have recognised that 'they [the elderly] are tremendously more likely to make a claim in the next 12 months than any other group' many were nevertheless startled at the number of elderly (80%) who had lodged a claim with their insurance company in the last twelve months. While arguably the presence of medical insurance encourages many to utilise their cover even for the most trivial of ailments, the fact remains that deteriorating health is a reality of ageing and if the comforting presence of health insurance becomes unaffordable then everyday healthcare becomes unattainable.

In spite of these sobering figures some still claim that the costs of health insurance are at a realistic level. One insurance company manager argues that

> 'while private health care was becoming more expensive, it was still affordable for a great many people. What is happening in New Zealand is part of a world-wide trend, and no government can afford to meet all the costs of health care with its new technologies.'[64]

While it is arguable that 'in global terms, New Zealanders still receive moderately priced health care, even if it is more expensive than it was in the past'[65] the question is for how much longer? Premium rises show no sign of ebbing. Instead Aetna acknowledges that premiums are likely to

---

64 David Turner, general manager of Southern Cross, Sheeran, 'Asset testing still a reality,1997.
65 Sheeran, 'Asset testing still a reality,1997.

double in the next few years. 'We suspect all insurers will meet the increasing numbers of claims and increasing costs with further rises.'[66] Rising premiums and decreasing public care means that a great many elderly are left in the middle, unable to rely on public health care, yet unable to purchase health insurance.

> 'Premium rises reflected what was happening in the health market...With one of the key drivers being the fact that people are using the private sector much more for surgical needs. If you look beneath government announcements of one-off policies their funding is decreasing in real terms every year.'[67]

Figure 14 shows that of the elderly who currently hold health insurance, 24 percent of them would discontinue their policies if premiums rose by 20 percent. Following the trends such a rise would be upon the elderly within two years. Borren predicts that by the start of the new millennium insurance premiums would have doubled.[68]

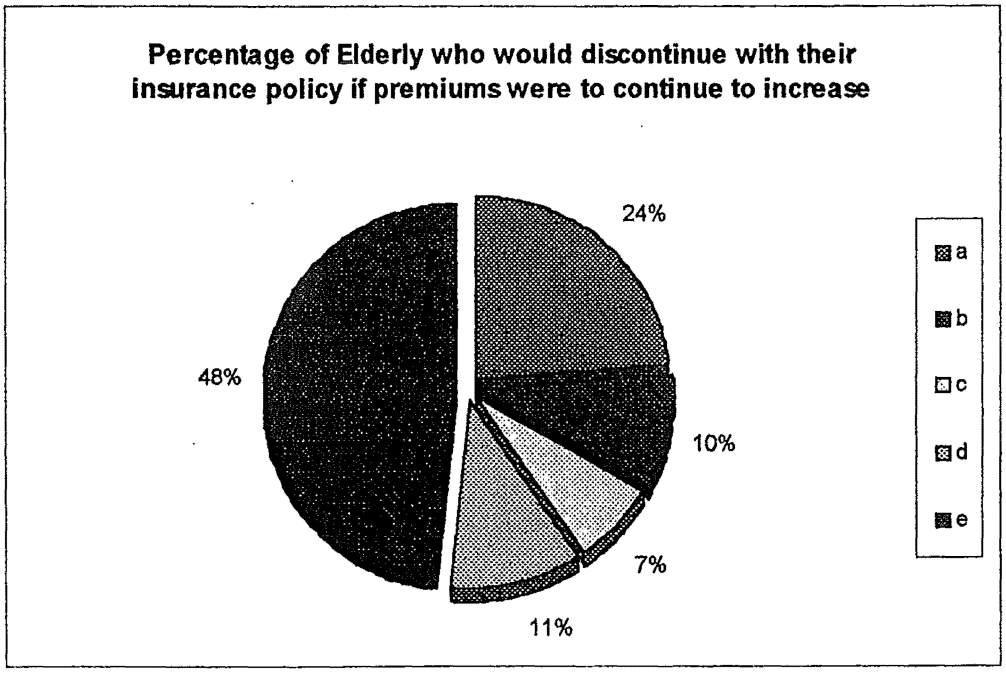

Figure 17 ***Source*****: Health Care Survey of the Elderly 1997**

---

[66] Consumer magizine, p29 July, 1997.
[67] Quoted by David Turner, general manager of Southern Cross in Holloway, 'Health Insurer raises premiums',1997,p.57.
[68] Borren & Maynard, *Searching for the Holy Grail in the Antipodes: the Market Reform of the New Zealand Health Care System*, 1993.

Legend:
a. (24%) would discontinue their policies if premiums increased by 20 percent.
b. (10%) would cancel after 30 percent premium increase:
c. (7%) would cancel if premiums rose 60 percent
d. (11%) would not discontinue their medical insurance coverage, even if the cost of premiums continued to rise steadily
e. (48%) Did not know and would decide at the time.

Based on these survey results 41 percent of the elderly would cancel their policies before the turn of the millennium. This could increase considering the large percent (48%) of those who said they would decide at the time of the increase. Access would then be at a critical level for the elderly as they would be unable to rely on the public system and unable to afford the private. In 1985, private care accounted for 12 percent of total health expenditure. By 1995, this had doubled to 24 percent.[69] The rise was 'more of the same' for Southern Cross which also increased premiums by an average of 12 percent in 1996 and again in 1997.[70] The companies are entitled to crank up their premiums because, after all, they are a business with an overriding goal of making money. Only two of the insurance companies in New Zealand are non-profit. But the burden of premiums topping $1000 annually - $1800 for superannuants - is making health insurance a less attractive option for many people. Therefore, their health care is pushed back onto a public system already struggling to cope without inheriting more patients from the private system.

> 'The position facing elderly people with health insurance is especially tough. They may have been paying premiums for years without making claims, but just as they reach an age where their reliance on the insurance increases, they get hit with a sharp rise in premiums. For many, this will force them to drop their policies and place them back at the mercy of the second rate public system.'[71]

What seems to be happening as a result of premium rises is that some elderly, instead of cancelling their policies altogether, are having them reduced down. By reducing cover to the bare minimum, surgery only for example, they are protected for the 'big one.' According to Unimed managing director, Dermott Martin, 'the elderly are re-configuring their cover so they

---

[69]Quoted by David Turner, general manager of Southern Cross in B. Holloway, 'Health Insurer raises premiums',1997,p.57.
[70]Holloway, 'Health insurer raises premiums',1997.
[71] J. Anderson, Operation Kiwicare, Truth, 23 Aug 1996.

are able to afford the costs of say a 'big bang' and insurers are responding by offering reduced policy cover'[72]

According to Consumer magazine, people should consider getting health insurance cover because access to public health care is worsening, . In July 1997 Consumer wrote a lead article on the necessity of health insurance in order to have ease of access to health care. This was a different position from the earlier stances taken in relation to the issue. On each previous occasion when they looked at this topic, they made it clear that they did not think health insurance was necessary. They believed that the public hospital system, despite its much publicised difficulties, remained capable of dealing with the medical needs of the vast bulk of New Zealanders. Now, they said, they were not so sure. It is not the quality of care that concerns them because, by and large, the people and systems of the public sector appear to remain strongly committed to high standards. The issue they say is access

> 'The system is backed up, in many areas badly overloaded. Far too often, patients have to wait for lengthy periods with a painful and often debilitation illness, before they can be treated. Despite very extensive restructuring, and despite the issue having been at or near the top of the political agenda for many years, the problem is getting worse.'[73]

Consumer stated that evidence suggests too many New Zealanders may now be unable to rely on the public hospital system to deliver important surgical and other hospital based medical care within a reasonable time frame. As a result, Consumer advocated that many people should consider taking out health insurance in order to secure access to necessary care.[74]

With the government now predicting that the already lower levels of elective surgery being performed in public hospitals will be halved within the next three years, the 1.4 million New Zealanders with private health insurance face the prospect of even steeper premium rises. A Health Ministry report finalised earlier this year on sustainable health funding said that the state would do 50 percent less elective surgery in next three years. The general manager of Southern Cross, said that figure was 'quite frightening' with the big driver behind recent premium rises being the burgeoning amount of elective surgery undertaken by the private sector as public hospitals, strapped for cash, concentrated mainly on acute surgery.

> 'That has been going on for several years now, but when we read that elective surgery in public hospitals is to be cut even further, I wonder if we have really taken on board the implications.'[75]

---

[72] Interview with Dermott Martin,1997.
[73]Consumer magizine, 14 July 1997,p.29.
[74]Consumer magizine, 14 July 1997,p.29.
[75]Sheeran, 'Private health costs sure to rise',1997.

The implications are not ambiguous. If the current trends of public system cuts and corresponding premium rises continue, people paying for top-shelf medical insurance will see their premiums double in under five years. The situation is little better for people who take out the more popular regular options that provide for surgical, doctors' visits, prescriptions, and some specialist care for a family with two or more children. Their annual health insurance bill is up to $1308, and if you add the 25 percent 'co-payment' made when claiming on policies, it brings the annual health spend to $1635. That is around 4.5 percent of the average wage, and based on increases during the past three years, could rise to nearly 7 percent in a little under five years. The news is equally bad for the 60 percent of the population who don't have medical insurance, and who must take on board even greater financial risk if they fall ill. Turner stated that New Zealanders were going to have to get used to health care spending moving further up their budget priorities.

> 'Then there will be those people who just cannot afford health insurance, and that is a real worry for us, and not just from a strict business point of view. As a not-for-profit organisation, we have a strong philosophical view that we want to see as many people as possible with adequate health care.'[76]

The general manager of the largest insurance company states that 'there is a real concern New Zealand would end up with a two-tiered health system, one for the wealthy and one for the poor' [77] Affordability issue means many will not take out the cover, yet according to Unimed 25 percent of the population will always have insurance. But for many especially the elderly on fixed incomes, health is one of the first covers to go, before house and contents insurance and even before car insurance.[78]

Increasing numbers of elderly are finding rising premiums due to increased claims a financial barrier to accessing adequate health care. The evidence of this is in figure 17 Only 7 percent of the elderly find that health insurance is most accessible to them, with almost 60 percent finding health insurance the least financially accessible. With predicted premium rises by all the major health insurers this scale of accessibility is only going to move further to the right of the spectrum, making health insurance even less financially accessible to the elderly.

---

[76] Sheeran, 'Private health costs sure to rise',1997.
[77] Sheeran, 'Private health costs sure to rise',1997.
[78] Dermot Martian, Id., n 61

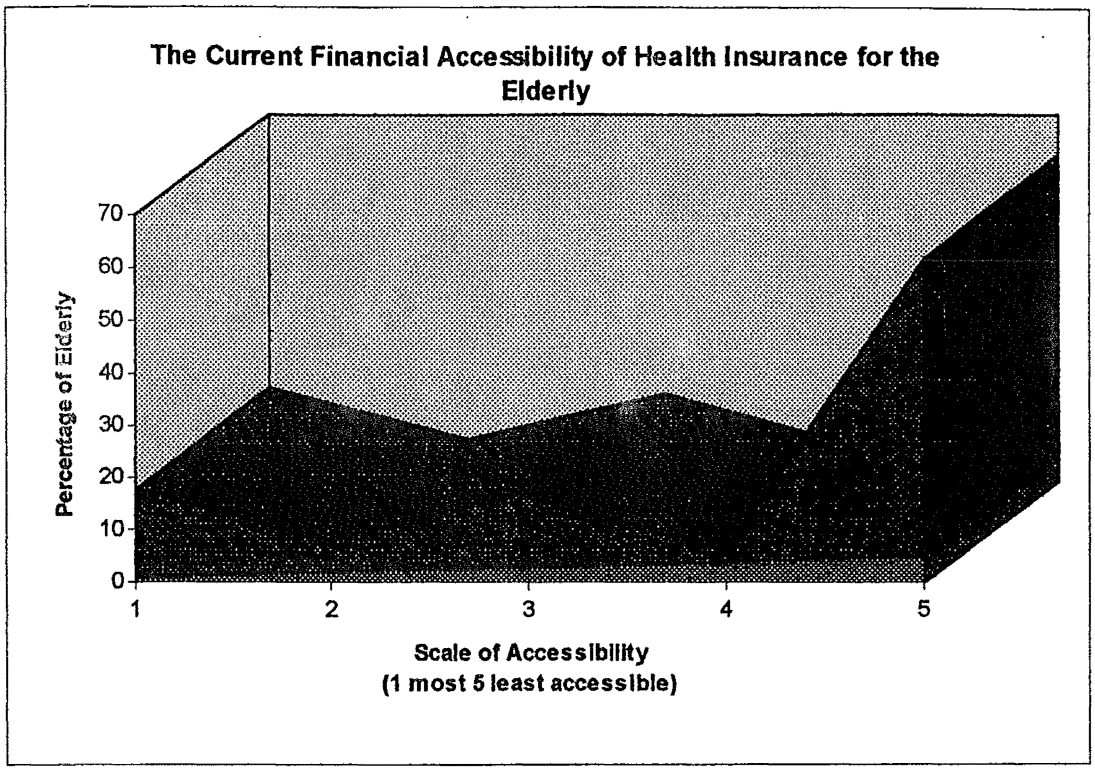

Figure 18 ***Source*****: Health Care Survey of the Elderly 1997**

Conclusions

This chapter sets out to answer a number of questions put forward which were designed to test the validity of the hypotheses in Part Two. These postulated first, that the Coalition government will continue shifting health care into the private sector while effectively reducing the state's role of social responsibility. As a result increasing financial pressure and continuing uncertainty is being placed on those over sixty five regarding access to health care services. Evidence of this was collected from survey results of 230 elderly, interviews of elderly and of insurance companies, reports and articles. The first finding established the government's continuing determination to privatise health care. This was manifested in four ways, first, from announcements made by the Minister of Health and the former Prime Minister who signed the coalition agreement. There is a substantial degree of evidence which suggests that continuous integration of the private sector in funding health care will be pursued by the current coalition government. The arrival of new Prime Minister, Jenny Shipley, is unlikely to alter the course of the ship, a fact which previous statements support. Second, the removal of New Zealand first MP, Neil Curtain due to outspoken behaviour and actions voiced at opposition to the privatisation policies. Third, statistics backed up the shift graphically showing an increasing proportion of private health funding. Physical evidence of this is found in the building of private clinics, hospitals and resthomes, coupled with a reduction in public funding. Fourth, the macro trends of reducing public spending over the last 15 years as discussed in depth in chapter two.

The second finding concerns the increasing financial pressure on the elderly and the resulting impairment in accessing health care services. This has shown to be manifested in two main ways; first, through the massive increases in private health insurance premiums which has resulted in a considerable number of elderly cancelling their policies. This is reflective of the increased pressure on the insurance market due to considerably more usage by the elderly which in turn is a result from the governments withdrawal in providing the services in the public sector, such as elective surgery. Second is the financial pressure which the government has exerted by the imposition of income and asset testing of those elderly who need care. This results in them having their asset base eroded away with wider social repercussions impacting on them and their families.

The third finding concerns the continued uncertainly created by government withdrawal and private sector involvement. There are four main areas of concern for the elderly, the first and most pressing of which is the reduction of public funding into health care. Second was the involvement of private health care, namely private insurance. Third, the overall fundamental concern for those elderly surveyed (80 percent) is with access to health care services. From overseas experience and the evidence collected here it is difficult to have any confidence in the ability of the private insurance market to make health care coverage accessible to those over 65. Comments from insurance company managers did little to alter this finding, rather their inability to accommodate the elderly was highlighted.

The second part of this chapter examined the hypothesis that the shifting of funding sources are creating fundamental problems of access for the elderly as claims on insurance premiums rise forcing many elderly to cancel or reduce the coverage of their policies. From the information available there was evidence to suggest that there are fundamental problems of access for the elderly as a result of the governments withdrawal from funding health care and the consequent involvement of the private sector in providing it. Evidence of this was manifested in two main findings. First, the increased size of waiting lists with backlogs in such areas as hip and knee replacement, cataracts, and similar elective surgery predominately required by the elderly. Introduction of the booking system is bad news for those on waiting list as many will be removed after the proposed reshuffle. Second, the cost of private health insurance to cover medical procedures which are no longer available in the public sector.

The Minister of Health admitted that the only way to get equity in access to health care provision is to ban private health insurance. Such inequity is becoming apparent with the skyrocketing cost of health insurance which has seen large numbers of elderly cancelling their long held insurance policies. Already the numbers of elderly adds who are not covered by private health insurance is high (some 46%) and, more importantly, is on the increase with no signs of slowing.[79] For the 35 percent who are current holders, over 40 percent said they would

[79]Sheeran, 'Private health costs sure to rise',1997,p29.

cancel their policies if premiums were to rise to the level they have been predicted to by the turn of the new millennium. Another 48 percent would decide at the time. This poses fundamental problems as to the distribution of health care resources if the system is run on a basis of an ability to pay and a rapidly growing group do not have this ability.

However, there are options for the elderly, in particular, reduction in cover to the extent that they are only protected against the 'big one.' This means many policy holders will have to pay out of pocket for almost everything else that is not major. The survey finding found that of those elderly who had insurance, 80 percent of them had made a claim in the last 12 months. This is a staggering finding but not surprising to the insurance companies. What this shows is that the private sector is becoming a critical supplier of health care to this group further highlighting the concern above.

The United States has a two tier health system distinguishing those who can afford insurance from those who cannot. An Insurance company manager is concerned that New Zealand would end up in the same situation and there is evidence of this already. When the current financial accessibility of health insurance for the elderly was measured it was found that 60 percent of the elderly surveyed said health insurance was extremely inaccessible. This should be cause for alarm.

Reforms have not provided improved ease of access to quality services as advocated. Instead access to health care services, as shown in other countries, has created fundamental distributional concerns. While governments may make health-policy decisions about populations, it must not be forgotten that at the point-of-service delivery there is an individual patient, not a population. The common argument advanced to improve quality and patient access is for the government to increase overall health care expenditure. Evidence here suggests that such an approach would go a long way to alleviating many of the problems that have arisen in the health system.[80] The lack of funding must not obscure the fact that much responsibility for the current crisis lies with the private sector which distributes health care on an ability to pay rationale.

---

[80] L. Levy, 'Throwing money at hospitals won't cure their ills', *The National Business Review*, Feb. 21 1997.

CHAPTER FIVE

Validation of the Macro Issues: Implications of Private Sector involvement

The first four chapters have dealt with the stated hypotheses which postulated the following: 1) that the government's transition from a welfare state to a market framework for the provision of health care has fundamental flaws in its ability to provide equity of access to the elderly; 2) that the government is decreasing the state's role in providing health care, resulting in a shifting of provision from the public to the private sector; 3) that these shifts are creating fundamental problems of access for the elderly as claims on insurance policies increase due to reduced services in the public system. As insurance premiums rise many elderly are forced to cancel or reduce the coverage of their policies; 4) that the Coalition government will continue to transfer health care into the private sector, effectively reducing the state's role of social responsibility and perpetuating the access problems.

This chapter intends to deal with the questions which address the macro issues in this thesis drawn from the theories in chapter one. Evidence from the case study, interviews and health reports are consolidated to support and refute the arguments put forward. This chapter begins by analysing the implications of the market reforms in relation to the elderly with reference to the findings of the case study. It then investigates the existence of moral hazard and adverse selection within the insurance companies and makes an assessment as to whether the private sector is capable of providing for the health care needs of the elderly in the new millennium. Furthermore, the experimental public policy transformation of health care in relation to the elderly is reviewed at a macro level. Finally consideration is given to adjusting the current health agenda for the new millennium.

Implications of Market Reforms

Has incorporating the market into health care actually achieved what advocates said it would? In order to answer this a case study of the elderly was undertaken with a focus on how market reforms have impacted upon the elderly as a group.[1] It has canvassed issues such as insurance coverage, waiting lists, financial accessibility, access to services and other essential issues which assess the effectiveness of the reforms. Based on the case study and varied

---

[1] Consult Appendix A for survey questions.

primary sources, it appears that a number of the advantages which advocators of the reforms purported would result from changes to the health care system have not in fact materialised. Conversely, many side effects which were predicted have become a reality for the elderly.

Chapter one reviewed advocates arguments that market incorporated health care had a number of advantages, all of which reflected the assumption that health care is a commodity. First, it was claimed that such a move would be more responsive to consumer preferences and contribute to innovation and equal treatment. Second, rationing by price would be a fairer system of meeting need than rationing in other ways. Third, the market would be more flexible, bringing about a large expansion to hospital-based services, and fourth, removing bureaucratic inefficiency would involve greater consumer and provider responsibility. This section seeks to critique the validity of these claims by assessing the effects of these alleged advantages on the elderly.

Harris and Seldon argue that the market in health care responds readily to the needs of those who require the services it provides and then accommodates what they choose, as well as bringing in new ideas and change.[2] Further, they argue, it offers equality in treatment. Referring back to the story of Iris Kennard in chapter four it can be appreciated how the private sector operates at the interface level.[3] Once Iris had decided that she would pay for her cataract operation out of her own pocket instead of waiting the estimated three years for the operation in the public system she found that the private sector were indeed very responsive to her needs operating with efficiency and effectiveness. The cost was a major factor in her deliberation. However, due to the necessity of the situation she dipped into her savings for the $3000 dollar fee. Iris's case highlights the issue of accessibility to health care based on an ability to pay criteria. The obvious problem with the first 'market advantage' is that it presupposes the person requiring care can afford to take out either private health insurance or pay for essential treatment out of their own pocket. In fact, case study results showed that only 35 percent of elderly are currently covered by health insurance. As figure 18 shows 65 percent of those surveyed were without cover, with over 19 percent of this total having just recently cancelled their policy because of premium rises.[4]

---

[2]R. Harris and A.Seldon, 'Not from Benevolence'. *Institute of Economic Affairs*, London 1977.
[3]The interface level is where the markets created by the private sectors connect between the availability from the system to the purchase and usage by the elderly.
[4] Health Care Survey 1997.

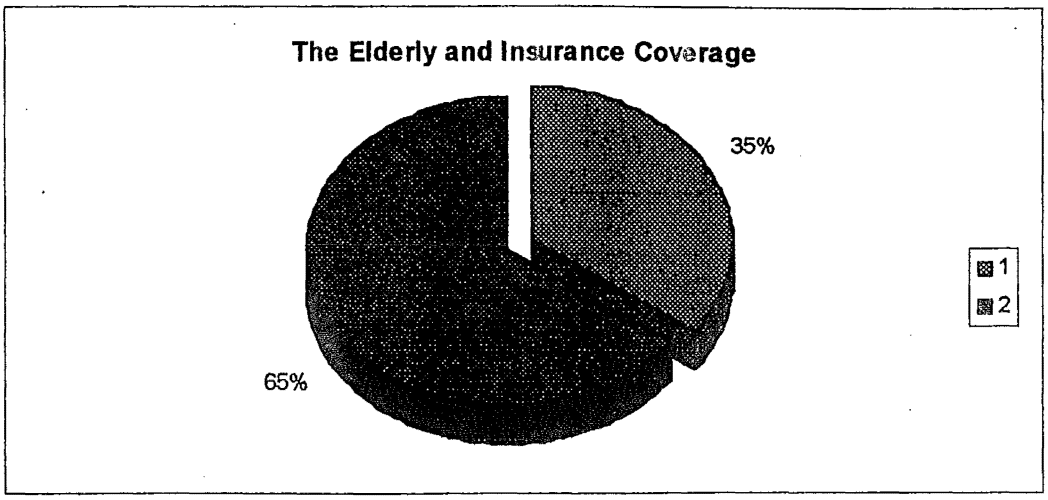

Figure 18 ***Source*****: Health Care Case Study of the Elderly 1997**

Legend
1 - (35%) Number of elderly currently covered by private health insurance
2 - (65%) Number of elderly without insurance cover

When asked what the preferred method of paying for health care was, 23 percent of elderly said they were prepared to pay for it out of pocket.[5] In order to receive the benefits which the private sector claims to provide, the patient must be willing or, more importantly, able to pay. Financial rationing then becomes the main mechanism to control the use of resources in health care.

The financial ability of those over sixty-five to pay for health care appears minimal. Table 19 shows that the median income for a person over sixty-five is $12,177 dollars per year. Over 30 percent of elderly have an income which is less than $10,000 annually. Approximately 11.5 percent of elderly receive an income of between $15,001-$20,000, and just over 15 percent of elderly receive an income above 20,001. By far the majority of elderly fall within the income bracket of $5,000 - $15,000

[5] This is higher than the actual level of payment out of pocket for the entire population in 1995 which was 17 percent, (excluding insurance policy costs which where a further 6%) as cited in 'Insurance picks up the tab'; *The Evening Post,* 24 September 1996, p.6.

Total Yearly Personal Income by Age and Sex for People Aged sixty-five and Over, 1996

Total personal income	Age and sex					
	65-79		80+		Total 65 +	
	Male	Female	Male	Female	Male	Female
	Percent					
Loss	0.2	0.0	0.1	0.0	0.1	0.0
Zero income	0.3	0.5	0.5	0.7	0.4	0.6
$1 - $5,000	1.7	2.3	3.2	4.2	2.0	2.7
$5,001 - $10,000	31.8	33.0	28.2	24.0	31.2	30.8
$10,001 - $15,000	33.7	42.8	36.7	45.7	34.2	43.5
$15,001 - $20,000	11.7	11.2	12.7	13.8	11.9	11.8
$20,001 - $25,000	6.6	4.3	6.7	5.1	6.6	4.5
$25,001 - $30,000	4.8	2.4	4.6	2.9	4.8	2.6
$30,001 - $40,000	4.2	1.9	3.7	1.9	4.1	1.9
$40,001 - $50,000	1.9	0.7	1.6	0.7	1.8	0.7
$50,001 - $70,000	1.5	0.5	1.1	0.5	1.4	0.5
$70,001 - $100,00	0.7	0.3	0.5	0.2	0.7	0.2
$100,001 or more	0.8	0.2	0.4	0.2	0.7	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Median income ($)	12,360	11,658	12,459	12,312	12,378	11,832

Table 4 *Source*: **Statistics New Zealand, 1996 Census of Population and Dwellings**

The amount of income that individual superannuants need to cover their living expenses depends to a large degree on their housing costs. New Zealand has a high rate of home ownership in all age groups and people in the retirement age group are considerably more likely than others to own their home without a mortgage.[6] Table 4 shows that almost three quarters of elderly over sixty-five own their own home without a mortgage, with only around 8 percent with a mortgage and 10 percent renting.

[6] Statistics New Zealand, 1996 Census of Population and Dwellings.

Housing Tenure by Age and Sex for People Aged Sixty-five and Over 1996

Housing tenure	Age and sex					
	65-79			80 and over		
	Male	Female	Total	Male	Female	Total
	Percent					
Owned with mortgage	8.5	7.6	8.0	4.7	5.4	5.2
Owned without mortgage	74.5	72.4	73.4	73.1	67.5	69.5
Owned, mortgage not specified	2.5	3.3	2.9	4.6	4.9	4.8
Provided rent free	3.4	3.7	3.6	5.2	5.6	5.5
Rented	9.1	10.5	9.8	9.6	13.0	11.8
Not owned, rental status not specified	1.9	2.5	2.3	2.9	3.5	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 5 *Source*: Statistics, New Zealand 1996 Census Population and Dwellings

However, as figure 20 shows, housing remains the largest item of expenditure for superannuants. Among superannuant households, 21 percent of expenditure went on housing in the 1992/93 and 1993/94 March years, slightly more than in other households. Other major items of expenditure for superannuant households were food and household operation (both 19 percent), transport (15 percent) and personal and health services (9 percent).

Weekly Household Expenditure by Expenditure Group, 1992/93 and 1993/94

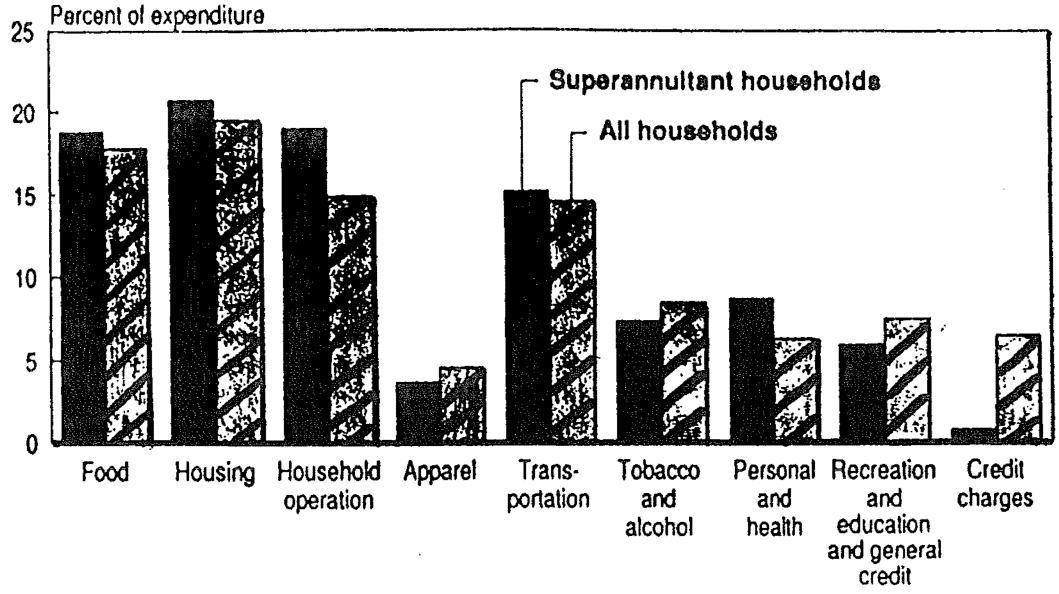

Figure 20 ***Source*****: Statistics, New Zealand, Household Economic Survey**

Compared with other households, superannuants spent a greater proportion of their money on these items and less on apparel, tobacco and alcohol, recreation, education and credit charges.[7]

> 'Privatising has made things difficult for a lot of the elderly. You can't save on small income[s] and meet large premiums. The pension has shrunk so much, prices and charges have got too high...'[8]

Figure 21 shows diagrammatically how the elderly perceive their ability to adequately access health care after the implementation of the reforms. Only 2 percent of the elderly surveyed thought that government reforms had greatly improved accessibility to health care services, while 20 percent found that there had been no difference. 76 percent of the elderly stated, however, that health care was less to much less accessible.

---

[7] Statistics New Zealand, 1996 Census of Population and Dwellings.
[8] Comments made by an elderly person who was surveyed in Christhurch 2 October 1997.

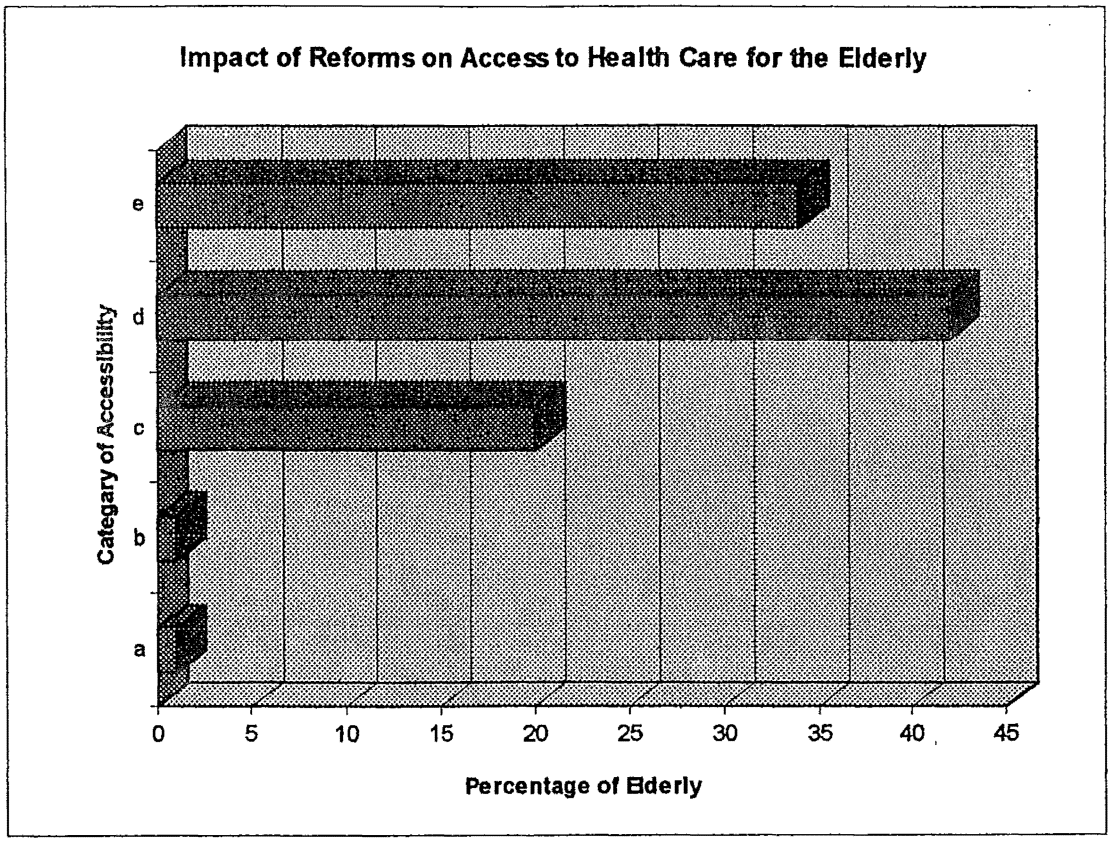

Figure 21 *Source:* **Health Care Case study of the Elderly 1997**

Legend:		
a ~ greatly improved accessibility	**c ~ no difference**	**e ~ much less accessible**
b ~ more accessible	**d ~ less accessible**	

For three quarters of the respondents the reforms have made health care accessibility a real issue with finance seen as the main impediment to access;

> 'Health care is only for people who have the money to buy it. Justice is a commodity, if you can't afford to pay for it, you don't get it'[9]
>
> 'Access to surgery should not be dependent upon one's ability to pay for private care'[10]
>
> 'In our society we now have a user pay[s] system [which] has gone too far, a great number of our people cannot afford to meet these extra costs'[11]

The elderly are feeling robbed in a new environment which has imposed a system completely contradictory to previous public policy. Evidence suggests that the elderly have been the victims in the market reforms, they are the ones being squeezed out of the system. Ian Powell, of the Association for Salaried Medical Specialists, states that those he represents feel very helpless about what is happening;

---

9 Comments made by an elderly person who was surveyed in Christhurch 2 October 1997.
10 Comments made by an elderly person who was surveyed, 1997.
11 Comments made by an elderly person who was surveyed, 1997.

> 'I see a lot of people quite distraught and upset about what's happening, and a sense of powerlessness as well. There's a belief that doctors have a lot of power, but it's just not the case. I think there's an increasing level of despair and frustration among specialists and among health practitioners generally. They know the demand is there, but the resources to do the operations are not. They know that people are suffering and there will be no end to their suffering.'[12]

The feeling is particularly strong among the elderly. 'Many are convinced', says Ross Ogle, a GP in Tauranga who treats large numbers of elderly, 'that the government is going to strip all state help to the minimum and make them pay twice for everything. A lot of them do feel they're about to be abandoned.' He recalls a 75 year-old he saw recently who was facing a hip operation. She was told by the hospital that she couldn't be guaranteed a place in intensive care but would have to take her chance in the general wards.[13] Such treatment is not uncommon and reflects the impact of reducing funding.

The market is said to bring new ideas and change to the health care system. Such innovation is evidenced by a number of initiatives taken by insurance companies, for example, the reduced cover policy. Premium rises over the past six years has resulted in the total pool of uninsured being reduced as much as 10 percent,[14] with a large number of these cancelled policies being held by the elderly.[15] Figure 12 in chapter 4 shows that 19 percent of elderly have cancelled their insurance with premium increases being the direct catalyst in 98 percent of them. To counteract this problem insurance companies have come up with an innovative way to retain elderly policy holders after premium rises have occurred. They simply offer a reduced cover. For the company it means they are able to retain the policy holder and their annual premium each year. It also means that the company covers the elderly for less care, reducing the avenues available for putting in a claim which effectively reduces pay out costs for the company. For the policy holder it has important implications. First, the policy is reduced to cover the elderly for less medical problems which might arise. This means that they will have to either rely on the shrinking public sector which is reshaping itself to ultimately provide only acute care, or pay out of pocket for health problems which are not covered in their new downsized insurance policies. Second, the cost of the new reduced policy premium is around the same price as the original policy which covered the elderly for a lot more.[16]

---

12 Powell I, 'Public Health Trend Concern', *The Dominion*, 21 May 1997.
13 Comments made by Ross Ogle GP in Greerton, Tauranga, as cited in Welch.D, 'The Nation's health', *The Press*, 1 Novemeber, 1997.
14 'High cost blamed for health insurance fall', Van den Bergh. R, *The Dominion*, 19 November 1996, p10.
15 Dermott.M the Christchurch branch manager of Unimed, 1 October 1997, 10am at 163 Glouchester Street, Christchurch
16 Information gained from Interview with Dermott Martin, 1997.

> '[I]Have changed my cover from full to 'surgery only' because of premium increases [I]would prefer to have retained full cover'[17]

The benefits gained by the insurance companies and the disadvantages for the elderly policy holder reflects the imbalance of power in the situation. The inherent danger in this is that the elderly continue to lose out and as premiums rise, the procedures included in a reduced cover policy will diminish to the point where the policy holder is covered for only very serious health problems. Other non-life-threatening procedures, such as hip replacements or cataract operations, would have to be paid for out of pocket or forgone altogether. This type of market adjusting is creating financial uncertainty and hardship, not to mention long-term suffering from easily treated health problems. This is a notable example of how new ideas and change by the private sector in the market are directed at serving the private sector's own interests.

One claimed advantage of implementing the market in health is that it makes the system more responsive to consumer preferences. What this translates to is that those paying for care should effectively have the right to choose who provides that care. Technically this theory applies in the public system, but reducing budgets is making this impossible. Health care in the private sector operates by giving the person requiring care the right to choose the professionals they want to have treating them. In fact, most will be referred on to health professionals by local General Practitioners. Yet this private sector accommodation of choice is proving to be costly to the company insurer.

> 'If people have the cover, they want the best and most expensive treatment by the best health professionals ...if you are insured then the resources will be available and ultimately used...a lot more procedures are done a lot earlier in the disease process, from what used to happen.'[18]

The concern expressed here by insurance companies is that insurance resources are being overly utilised by policy holders to the detriment of their profit margins. Recent revelations have shown that the Medical Association has claimed that health insurers are asking surgeons to undercut colleagues' prices. Dr Brian Linehan said he feared the practice was becoming widespread and could jeopardise patient safety.[19] The Association was aware of cases where insurance companies asked surgeons to undercut prices previously quoted by other surgeons. The Association had serious concerns about the trend and doctors were worried some companies were using their monopoly to bring prices down.[20]

> 'There could be situations where patients are forced to go to surgeons or secondary care providers not because of their professional suitability but

---

[17]Comments made by an elderly person who was surveyed in Christhurch 2 October 1997.
[18]Interview with D.Martin,1997.
[19]Is chariman of the New Zealand Medical Association as cited in M. Alexander, 'Cut price surgeons preferred', *Sunday Star Times*, 27 July 1997.
[20]Dr Linehan was quoted as saying in M. Alexander,'Cut-price surgeons preferred', *Sunday Star Times*, 27 July 1997.

> simply because of price. If we carry that even further, people could be forced to go to unappropriated specialists and people operating outside their specialists simply because they are offering to do something at a cheaper price.'[21]

Dr Linehan said patients would not appreciate insurance companies selecting surgeons.

> 'The implication is that it will be on the basis of which is the cheapest rather than the one who is best for you. The practice stemmed from insurance companies trying to cut their costs.'[22]

However, that is exactly what is being proposed by Aetna, which plans to contract doctors to perform operations. Aetna purports that it is a viable way to drive the health care dollar further and to keep premiums from rising at the current rate. Normally clients can choose the specialist or doctor they want when a medical problem arises and then simply send the bill to the company. However, if Aetna proceeds with its proposed contracting plan then consumer choice may become a thing of the past. The potential outcome is that where an Aetna client's G.P is not on the insurance companies contract schedule and is charging more than Aetna's rate, the client would be liable for the difference. Further, there is concern that the insurance companies will dictate what sort of care the patient gets. White points out that medical services provided by contractors is a problem already experienced in the United States, with doctors consulting with insurance companies as to whether a specific treatment will be applied and made available.[23] If successful, Aetna's profit-orientated proposal will create a breakdown in the consumer choice aspect of the market advantage. Once such a precedent is created it will not take long for other insurance companies to follow this economically-driven initiative.

Advocates of the Market consider rationing by price a fairer system of meeting need than rationing in other ways. It is easy to agree with this if one adopts the private sector's perception of health care as an ordinary commodity. In order to understand the so called 'market advantage' of this form of rationing, one must comprehend the rationale and logic behind the market advocate's belief as to who benefits from this new system. To do this two scenarios set in the reformed tax based health system are created. Scenario one involves a middle aged 45 year old executive with a gross income exceeding $100,000. She pays tax of $.33 of every dollar earned to be divided into the various social policy programmes by the government. Her nett take home pay is $67,000. $33,000 of her income is paid to the government on an annual basis and the executive's health care is taken care of. If she gets sick she can expect to get the necessary treatment, she does not have to pay for it out of her own pocket or through annual premiums. Scenario two involves a 75 year old Pensioner who has a gross taxable income from the government of $12,177. Such a person will pay $2922.48 in

---

[21] Alexander, 'Cut-price surgeons preferred', 1997.
[22] Alexander, 'Cut-price surgeons preferred', 1997.
[23] J.White, One Network News, 13 Janury 1998.

tax with an annual take home of $9,255.00 per year. He will get the same care despite his much smaller tax contribution.

The observation which market advocates highlight is that the variations in tax contributions between the scenarios are significant. This is important considering that the health care needed by the 75 year old is likely to be much higher than that by the 45 year old, yet their actual individual contributions to health care do not reflect this under a publicly funded health care system. The 45 year old, in effect, subsidises the 75 year old for who makes little health care contribution (even though he has done so throughout his life). Compare this with the market involvement in health care. The government reduces the tax take as it needs less money to run the system because people are paying for their care through private health insurance companies. Those who fall into the scenario one category retain much more disposable income which increases greatly as their income rises because tax cuts have a little or no impact on low incomes but a large impact on high incomes. Each person is now paying for their own health care; no one is cross subsidising as under the old system. This is the market advocate's notion of fairness.

The flaw in the system lies in the other significant difference between the executive and the pensioner - their personal disposable incomes. Under the market health care system, both individuals need to take out private health insurance in order to secure access to health care services when they require them. For the scenario one person this is no problem as the tax cuts pay for the annual premium. For scenario two, however, the situation is very different. Not only do they have to make provision out of their meagre disposable income each year but they must pay more for their cover than the executive due to the fact that they are older.[24] The extra financial outlay uses a larger proportion of the elderly's disposable income because they have less of it and because the tax cuts have minimal effect for them. Based on this only small higher socio economic groups would receive the advantage that the market brings in this type of society. Rice25 argues that the privatisation of social policy areas such as health care is part of a wider redistributive agenda. Income distribution is an issue so sensitive and important that it arouses intense political and social passions in all societies.[26] Yet is questionable whether New Zealanders are aware of the implications these reforms will have on the redistribution balance.

Another alleged advantage of the market system is that it is more flexible and brings about a large expansion of hospital-based services. From case study comments and other

---

[24] A person over the age of 65 pays approximately 60 percent more for their health insurance than does a person under the age of 65, refer comparison of Premium costs at Southern Cross, p26 of this chapter.

25 T.Rice, 'Can Markets Give Us the Health System We Want', UCLA School of Public Health, cited in *Journal of Health Politics, Policy and Law*, Volume 22, No.2, April 1997.

[26] L Bayliss'Economic failure in NZ and what should be done about it', *Prosperity Mislaid*, GP Publications, Wellington,1994 , p104.

commentaries,[27] however, it would appear that far from expanding the hospital based services,[28] the practice of closing hospitals that were not economically viable has been the norm. As the Minister of Health saliently put it, 'large hospitals will get smaller and small hospitals will close'[29] Many hospitals face an uncertain future as the drive for financial viability creeps through the New Zealand health system. Already increasing hospital closures has been witnessed since the commencement of reforms;

> 'Closure of small regional hospitals should not be used as a cost cutting exercise. People in smaller towns should have ready access to hospital care in their own area where family support is available.'[30]

Moreover, massive cuts to central region hospital services, including a 40 percent cut in the number of hospital beds have been forecasted. The widespread perception according to Welch is that public hospitals are under threat and the smaller ones will be completely eliminated.[31] The fear is that the larger hospitals are being turned into trauma centres with no wider caring role. The CHEs are being forced into a 'business model' straitjacket that does not fit. The darkest thought of all is that they are being groomed for purchase by the private sector-being deliberately kept short of funds and resources in order to prove a) their inability to cope as public institutions and b) the desirability of them being privatised.

These fears are not unwarranted. In a leaked report from Coopers and Lybrand written for the Central Regional Health Authority it shows that only two of eight central regional public hospitals are clinically viable. The report defines clinical viability as the safety and sustainability of services offered and measures whether hospitals can provide safe and effective 24 hour cover. Masterton, Blenheim and Nelson hospitals were assessed as not viable and doubts were expressed over Hutt Hospital. The report studied scenarios which included cutting all inpatient services to the hospitals. The report predicted that these would be axed with remaining day patient services provided by private clinics. The hospitals and services which are seen as not clinically viable will be removed instead of improved. It is proposed that they will be replaced with greater privatisation through privately owned independent practice associations and health maintenance organisations, which operate private insurance-based schemes.[32]

It is questionable whether the government can realistically expect the private sector to provide the services which it has withdrawn from in the small rural areas. If it is non-viable for

---

27 See C. Guyan, 'Hospitals not viable, face cuts', *The Evening Post*, 1 September 1997 and D.Welch, 'The nations health', *Listener*, 1 November, 1997,p.18.
28 With the exception of a couple of superclinics recently opened.
29 Minister of Health Bill English on TVNZ interview with John Cambell, 21 October 1997.
30 Comments made by an elderly person who was surveyed in Christhurch 2 October 1997
31 D.Welch, 'The nations health', *Listener*, 1 November, 1997,p.18.
32 C. Guyan, 'Hospitals not viable, face cuts', *The Evening Post*, 1 September 1997.

government the private sector is unlikely to move in. The notion that the private sector will fill the void left by the state's withdrawal from health care provision also means that there is no guarantee that every area of need for the elderly will be met. Further, the concern for the elderly is that the private sector will focus on providing services which are most profitable for them, as has been the case in the provision of rest homes and private hospitals. The most likely occurrence, as in the United States, is a clumping together of services in the main areas, such as in Auckland and Christchurch, based primarily on population size. Areas such as in the bottom of the south island with declining population bases, places such as Gore, Invercargill, Dunedin and Oamaru will be unlikely to get substantial services from the private companies. Already this can be seen in Southern Cross's health delivery network (Figure 21).

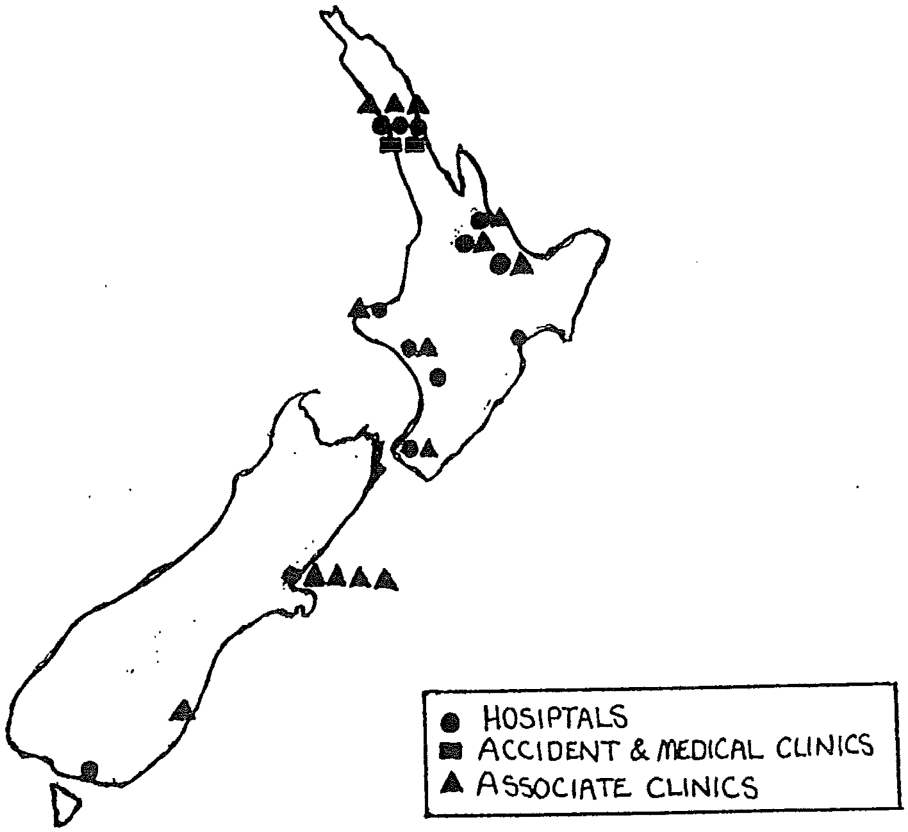

Figure 22 ***Source*****: Southern Cross annual report 1997**

Marked on the map are the private hospitals, Accident and Medical Clinics and Associate Clinics which Southern Cross provides. The North Island has more due to the greater population levels. Apart from the abundant Associate Clinics in Christchurch, representation is minimal in the South Island. Evidence of this prejudice was partly responsible for the United States government entering the marketplace in order to correct the geographical maldistribtion

of hospital beds caused by private companies moving hospitals to more wealthy suburban areas.[33]

The market is said to remove bureaucratic inefficiency and involve greater consumer and provider responsibility. Theory aside, the reality is that bureaucratic inefficiencies still exist. The private insurance market is a competitive one, anything which is competitive in this type of environment has added costs. In the insurance market these are called 'loading costs' and include extras such as advertising, administration, directors fees, premises rental and other overheads. The more competition, the greater the need for advertising, and consequently, the greater the loading cost added to premiums. Cost escalation in this type of market is a likely result.[34] The removal of bureaucratic inefficiency can really be seen as a transfer from public sector to the private sector the only fundamental difference is that the cost is coming directly out of the consumers pocket where previously it was coming out indirectly by route of the public purse.

Harris and Seldon claim that the incorporation of the market into health care involves greater consumer and provider responsibility.[35] Central regulation and control is reduced and individual choice is advanced. This introduces issues of what is the appropriate level of government intervention in a market orientated health system.[36] Effectively provider responsibility in the market comes down to whether there is demand and profit. It has little to do with ethical considerations where there is a need but an inability to pay, for example, counselling for abuse of the elderly. Consumer responsibility involves ideas of self interest and protecting oneself and one's family. The difficulty with this aspect of the market is that self interest involves many facets and often health care is subordinated to other necessities, such as mortgages and commodities. Unimed's branch manager commented, 'when the budget's tight health insurance is one of the first insurance policies to go, ahead of house and even car'.[37]

Market incorporation into health care has raised a number of fundamental concerns for the elderly and for the wider population as a whole. Impediments to accessing health care as a result of the cost of insurance premiums has led to serious equity concerns as has the insurance companies practice of reducing their policies while retaining their income. Government closure of rural hospitals and the private sector's development in clusters raise serious geographical maldisribution concerns.

Assessing the Presence of Moral hazard and adverse selection

This section examines the presence of moral hazard and adverse selection in insurance companies is examined. At the beginning of this thesis two theories about market failures were

---

[33] R.H.Blank, *Rationing Medicine*, Columbia University Press, New York 1988,p.98.
[34] R.Harris and A. Seldon, 'Not from Benevolence.' *Institute of Economic Affairs*, London 1977.
[35] Harris & Seldon, 'Not from Benevolence',1977.
[36] These issues are studied in more detail later in this chapter.
[37] M. Dermott interview,1997.

introduced which exposed a number of shortcomings in the insurance market. They were seen as ways in which failure could result in the provision of health care to the public. In order to assess whether these two negative aspects of the market were present both the insurance companies and a number of elderly were interviewed.

As stated earlier moral hazard or rather 'consumer moral hazard' arises because the very fact of being insured reduces the financial costs of treatment at the point of consumption, hence being ill is made a less undesirable state. The incentive to adopt healthier lifestyles is decreased and the probability of requiring care increases. The other aspect of consumer moral hazard is the effect of insurance when sickness occurs and services are demanded. A zero or reduced price at the point of use encourages a higher rate of consumption than would otherwise be considered efficient. Effectively there is a wedge driven between paying for the cost of what is provided and the value of or willingness to pay for what is provided. Thus, the market fails to transmit efficient price signals to consumers.[38]

To assess whether moral hazard is present amongst the elderly they were asked questions designed to gauge their view on being insured and whether they felt it was something to be exploited. Figure 26 shows the elderly's view on insurance utilisation. 50 percent of the elderly believe that they utilised the insurance coverage which they hold while 21 percent of elderly did not believe that they did utilise their cover. A further 29 percent did not think of their health insurance as something to be utilised.

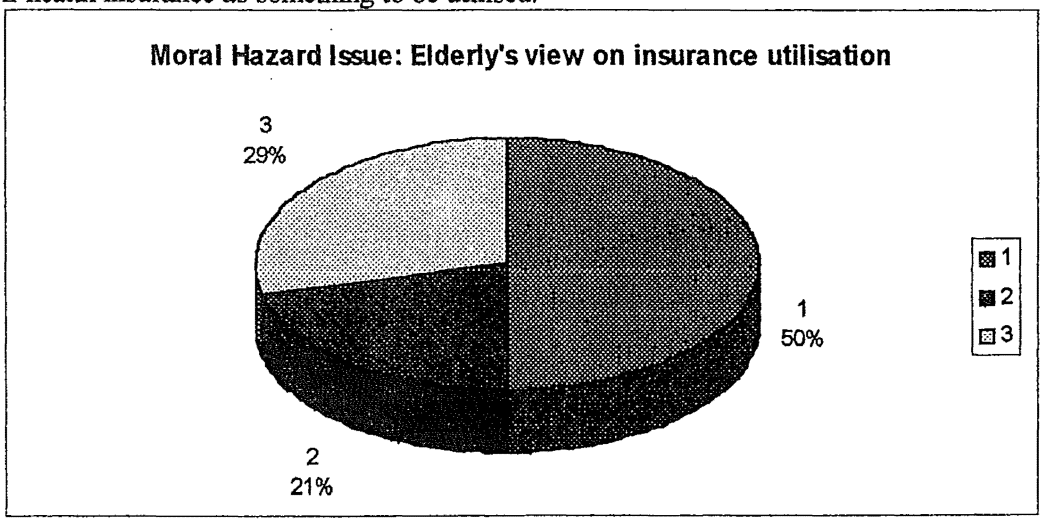

Figure 23 *Source*: Health Care Case study of the Elderly 1997

Legend:
1 (50%) believe they utilise the insurance cover which they hold
2 (21%) did not believe that they utilised their insurance
3 (29%) did not think of their insurance as something to be utilised

[38]Donaldson and Gerard, *'Economics of Health Care Financing'*, p.31.

These results suggest that the elderly indeed do utilise the insurance cover that they have. Figure 15 (in chapter 4) confirms this demonstrating that over 80 percent of policy holders surveyed have made a claim in the last 12 months. With nearly 30 percent of those surveyed saying that they did not think of their insurance cover as something to be utilised, it appears that while many are using the system they are not exploiting it. This is supported by figure 23 which shows that 80 percent of the elderly say that they use their health care coverage only when necessary. With 10 percent of the elderly claiming that they do not use it enough and only 10 percent saying that they use it in order to get their moneys worth, it appears that the level of insurance abuse amongst the elderly is rare and they are responsible with its use.

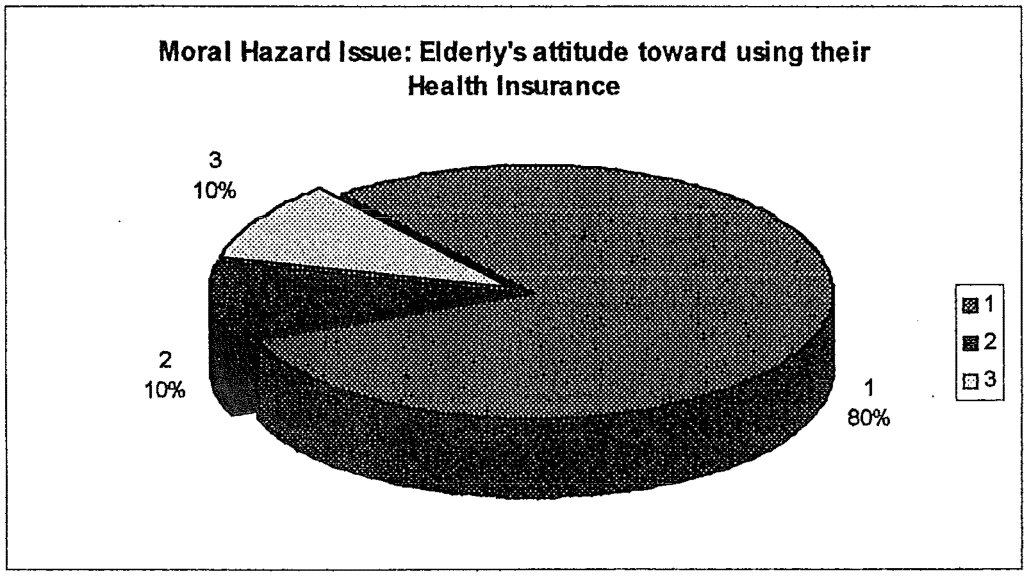

Figure 24 ***Source*****: Health Care Case study of the Elderly 1997**

From these relatively rudimentary case study results it would seem that moral hazard is not present in the attitudes of the elderly. The reason for this is the co-payment system which is an important impediment to the manifestation of moral hazard. Southern Cross (SC), the insurer with the largest number of elderly people with policies in New Zealand, has implemented this co-payment system where the policy holder pays a pre-determined amount towards the treatment of their care (the most popular is 20 percent). It is similar to an excess on car insurance, working effectively as a deterrent to frequent use. The co-payments are the corner stone for SC with over 75 percent of members opting for the 'Regular Care' program, which requires a 20 percent contribution towards their own care.[39] The user of the insurance pays 20 percent of the cost of the care out of their own pocket at the point of treatment, while at the same time paying a reduced premium compared to other policies which have no co-payment

[39] Interview with Fiona McCloud, Christchurch branch manager of Southern Cross Healthcare, 26 September 1997, 11am, 148 Victoria St, Christchurch, 1997.

allowance. According to the SC branch manager this has been extremely successful in deterring people from using their insurance unnecessarily.

According to the Southern Cross branch manager the group which is most likely to commit moral hazard is the white collar workers who have health plans which cover everything, i.e. the ones with no co-payments.[40] Interview with Fiona McCloud, Christchurch branch manager of Southern Cross Healthcare, 26 September 1997, 11am, 148 Victoria St, Christchurch The fact that usage is up amongst the elderly does not necessarily reflect the presence of moral hazard. Rather it may reflect the need for care which stems from the cut backs in public health and the shifting of elective surgery into the private sector.

As chapter one explained, adverse selection results from asymmetry of information in the insurance market; that is, buyers of insurance often have more idea about their risk status than sellers of health care insurance. Initially in a competitive market if the insurance companies have no idea of individual risk status a premium could be set reflecting the general health risk of the insured population. Thus, the premium paid by everyone who takes out insurance would be the same reflecting the 'average' risk level of the insured population known as 'community rating'. The elderly, for example, are considered a high risk group. For some members of the insured population who perceive their own risk level to be lower than average this community rating premium will be too high and they will elect not to take out health care insurance. The effect of this decision means, however, that the average risk level of those remaining insured will rise because it is people of lower-than-average risk who have dropped out of insurance. Thus, to cover the projected health care costs of this population group premiums must rise. Again, the effect is that those perceiving their risk status to be lower than the average of those remaining insured will exit the market and the cycle will continue. This process, whereby the best risks are selected out of the insured group is called 'adverse selection'.[41]

In a competitive system other phenomena would be expected to follow from adverse selection. The presence of a low-risk uninsured group of people presents insurance companies with the opportunity to tailor premiums to the levels of these individuals rather than the population risk. This is known as 'experience rating'. If fine distinctions can be made a premium will reflect assumed future risk level based perhaps on some idea of past history of personal and family health as a predictor for the future. As a result of this process, higher-risk groups (typically the lower-paid, elderly people and the chronically sick) will be required to pay higher experience-related premiums to maintain coverage, premiums which they may not be able to afford. The process by which low-risk individuals are drawn into low-premium plans is often referred to as 'skimming' or 'creaming off'. The elderly is a high-risk group and premiums for the over sixty five age group are the highest for any of the groups. They are

---

[40] Interview with Fiona McCloud, 1998.
[41] As outlined in Chapter 1.

being required to pay higher experience-related premiums to maintain their coverage. It is clear from the case study that those elderly who have insurance are indeed using it. Whether they are doing so unnecessarily is difficult to gauge accurately, but with over 80 percent of policy holders making a claim in the last 12 months one thing is very clear: claims are high and so too is the increase in premiums.[42]

The theory suggests that two groups of people are left uninsured as a result of this, those at low risk who trigger the cycle by pulling out of insurance at community rates, and those in high-risk groups who cannot afford experience-rated premiums.[43] From the evidence revealed it would appear that it is the high risk group, who are finding it increasingly difficult to finance their insurance with a continual increase in premium levels of 12 percent every year. The current cycle sees premiums rising due to increased demand on health care resources provided by the private sector because those services are now very difficult, if not impossible to obtain from the public system. As the premium prices increase many older people who have not claimed recently but may well have had a policy for a lengthy period of time (refer chapter 4, figure13) will cancel them. Figure 14 (chapter 4) shows that if premiums rise another 20 percent by 1999, then a quarter of elderly who have policies would cancel them.[44] 'Each time premiums rise 'a layer of policy holders are burnt off'[45] This trend is very concerning as it effectively means that only those elderly who can afford the cost of cover will have open access to health care provided through the private sector. Those who retain their cover will either be risk adverse, be dependent on their insurance and be able to afford insurance, or will have a known health problem. Many others in this grouping will have scaled down their insurance policy to partial cover, others will be forced to take their chance in the public sector.

This leaves the insurance companies with those elderly who are the 'bad risks'. They are the ones who use insurance on a regular basis or are the ones who have health problems or simply those who do not feel they can do without it. Effectively the total policy pool reduces and the claims increase. Consequently the margins for the companies are reduced. Unimed's manager commented, 'The more well elderly who pull out, the company are left with the adverse group and this becomes detrimental to both parities'[46] This is a fundamental flaw in the insurance market and is a example of how the market is failing and will continue to fail in providing adequate access to health care for the elderly.

---

[42] Refer chapter 4, Pp34-35.
[43] Refer chapter 4,p.36.
[44] As was evidenced in the survey of the elderly 1997.
[45] M.Dermott Interview,1997.
[46] M.Dermott Interview, 1997.

The Ability of Insurance Companies in Providing the Health Care Needs of the Elderly in the New Millennium

'Growth in the elderly [population] is now a problem for the insurance company'[47]

Are Insurance companies capable of providing the health care needs of elderly in the new millennium? The short answer is not under the current direction. The reasons for this are the costs of premiums set by the insurance companies which are causing financial inaccessibility, and the continual increases which exacerbate the problem. Consequently, many elderly are scaling down their policies to one which offers a reduced cover leaving them reliant on the decaying public system for their other health care needs or forgoing health care altogether. Based on the evidence gathered, this thesis predicts that the numbers of elderly without insurance will steadily climb as New Zealand proceeds further into the 21 Century.[48] This coupled with the withdrawal of government funding will put increasing pressure on the private sector.

Premium prices for this high-risk group are going to be expensive in the future, quite possibly too expensive for many of the elderly to afford. Trends in premium rises are likely to continue according to the major insurance companies. 12 percent increases on a yearly basis has seen premiums for the over sixty-five high risk group increase 400 percent in the last six years with no end in site.[49] Table 1 gives a comparison of the costs of policies for an Adult under sixty-five and an Adult over sixty-five at Southern Cross. The obvious difference here is the fact that those over sixty-five are paying around 60 percent more for their insurance then those under sixty-five.

---

47 F.McCloud, Interview, 1997.

48 In this section a number of premium projections for the next decade based from current and predicted trends are made, the rising premium levels suggest that this will result in a declining of policy holders, refer p26-27.

49 Refer chapter four, Pp 34-35.

'Members continue to make increasing use of their premium contributions, particularly in the area of elective surgery. Surgical claims have grown by 40.6 percent over the last five years as evidenced by the pay-out amount, for surgery alone, of $154.7 million during the last twelve months. This can be compared with an annual figure of $95.8 million in 1992/93. This reflects the increasing shift of non-urgent surgical procedures away from the state hospital sector and into the private domain - a shift which has continued unabated for several years.'[51]

Senario One: Projected Premium Estimates for the New Millennium						
Regular Care				**Regular Plus**		
	Under 65	*Over 65*			*Under 65*	*Over 65*
1998	$481.82	$1,178.10			$743.06	$1,574.50
2000	$603.50	$1,477.70			$854.27	$1,975.04
2002	$700.06	$1,853.63			$1,071.60	$2,477.50
2004	$816.60	$2,162.70			$1,249.90	$2,889.75
2006	$952.42	$2,521.85			$1,457.90	$3,370.61
2008	$1,110.90	$2,941.48			$1,700.49	$3,931.47
Ultra Care						
2000	$1,794.48	$2,864.02				
2002	$2,251.00	$3,592.63				
2004	$2,625.57	$4,190.44				
2006	$3,062.46	$4,887.74				
2008	$3,572.05	$5,701.05				

The figures in scenario one are based purely on the evidence gained from interviews and an assessment of current trends and annual reports. It gives an indication of what premium levels those under and over sixty-five could well expect to pay if current trends persist. It is a conservative prediction of premium rises for the next ten years. It projects a continuation of the annual 12 percent rise for the next four years and then a decrease to 8 percent for the following six years. The reason for the projected reduction in premium increases is a prediction of stability which will come about when the government finally settles on the level of provision it is willing to provide. Once the government has finished reforming the health system and a degree of stability returns to the health environment, the insurance companies will know what level of elective surgery they need to provide. Consequently, the companies should be able to reduce the increasing premiums. Furthermore, as claims become more predictable for the insurance companies, the insurance market obtains a degree of certainty and price stability resulting in a stabilisation in policy holder numbers. This ultimately translates into a diminished need to increase premiums at such a high rate.

---

[51]Dr Hylton Le Grice, Chairman of Southern Cross cited in the Annual Report 1997,p2.

Senairo Two: Projected Premium Estimates for the New Millennium						
Regular Care				**Regular Plus**		
	Under 65	*Over 65*		*Under 65*	*Over 65*	
1998	$481.82	$1,178.10		$743.06	$1,574.50	
2000	$603.50	$1,477.70		$854.27	$1,975.04	
2002	$812.06	$1,988.39		$1,149.50	$2,657.61	
2004	$1,092.72	$2,675.58		$1,546.77	$3,576.08	
2006	$1,470.65	$3,600.26		$2,081.34	$4,811.98	
2008	$1,743.26	$4,844.50		$2,800.65	$6,475.00	
Ultra Care						
1998	$1,430.55	$2,524.70				
2000	$1,794.48	$2,864.02				
2002	$2,414.65	$3,853.82				
2004	$3,249.15	$5,185.70				
2006	$4,372.06	$6,977.88				
2008	$5,883.04	$9,389.44				

This is, however, a conservative estimation as figures in 1996 show that as the numbers of high-risk groups, such as the elderly, increase premiums rise as much as 20 percent a year.[52] Unimed is a company which has increased premiums at this rate. The figures in scenario two are based on a prediction of these continued high increases. The projection is for the premium rises at 12 percent to continue for the next four years, followed by a further increase to 16 percent in 2004 (as opposed to the decrease to 8 percent as in scenario one). The reason for this is the increase in work load of insurance companies which must satisfy the demand for more services as the government withdraws completely from its role in areas such as elective surgery. It is predicted that the total pool of policy holders will increase as people become aware that if they want access they have to have insurance. However, it is predicted that those who are in the low risk groups will chose not take out health insurance but rather pay out of pocket for care as they need it, possibly covering themselves for only the bare minimum (like surgery).[53] The effect of this is that while the total pool of insured people will increase, it is predominantly those who believe that they need the insurance and are likely to use it that will insure themselves. The low risk groups will take the chance and stay out of the market hence adverse selection continues. This effectively means that premiums will keep rising as the high risk groups, or rather those in need of care, continue to claim.

In Table 1 it is clear that the difference between the two levels of risk groups are significant. The price discrepancies are most notable between the 'Regular Plus' plan and the 'Ultra Care 400'. In the former plan the over sixty-five pay 144 percent more than those under sixty-five whereas in the latter plan those over sixty-five pay 130 percent more in premiums

---

52 Love.P'Going Private', , *The Evening Post,* 26 Oct 1996, p.17.

53 Many elderly (235) put 'paying out of pocket' as a prefered way of paying for HC refer chapter 4, p.28.

than the other group. If we consider scenario one ten years on this difference has increased substantially. 'Regular care' shoots up to a premium rate which is 164 percent higher than the under sixty-five's. However, the most significant changes occur in scenario two. In 'Regular Care' ten years from now, it is estimated that premium levels for the elderly will be close to $5000 per year. The difference between the two risk groups is significant, with those over sixty-five paying 180 percent more for their premiums than those under sixty-five. The important issue in this is that while there is a vast difference in premium prices, there is also a vast difference in income earned between the two groups. The average weekly income in New Zealand as at November 1997 is $624 gross.[54] For the elderly, their average weekly personal income is $234 gross.[55] If an elderly person has a 'Regular Care' policy it will cost them over 10 percent of their disposable income to pay the premiums for one year.[56] For a person under sixty-five earning the average wage and covered by the same health policy as an elderly person, the cost would constitute only 1.4 percent of their disposable income.

The fundamental future problem is that this premium figure is quite likely to be three to five times higher in ten years. Any rises in the superannuation level are not going to correspond to such large increases. Even if, as predicted in scenario one, premiums rise at the current rate for only four more years, then reduce by one third for the next six, they would still be almost three times what they are today. This would mean that the elderly would be spending around 23 percent of their disposable yearly income on private health insurance.[57] In scenario two the elderly would lose 37 percent of their disposable income just for basic health care coverage, or for a policy which provided them with a little more cover, 'Regular Plus' would absorb around 50 percent of their yearly income. For complete cover under "Ultra Care 400", the elderly would be faced with paying over 70 percent of their total yearly income.[58] Such trends are unsustainable for many elderly and the insurance companies recognise that as the elderly are faced with further rises they may lose large numbers of policy holders.

> '...there will inevitably be increasing claims, and therefore more costly premiums. Members have to carefully understand the reasons for this increasing burden in a changing environment, and why, it is now more

---

54 Television Three, 6 o'clock News on 19 November 1997

55 Statistics New Zealand, Census of Population and Dwellings, 1996.

56 Most people insured earn $40,000 to $65,000 a year says New Zealand health Insurance Association president James White who has warned that in the longer term people will continue to pay more in premiums. Premiums have doubled in the past five years and are expected to double during the next five years. One insurance expert predicted the cost of an insurance premium would eventually rise to between 5 and 6 percent of annual gross income. This he commented would rival the contributions some New Zealanders made saving for their retirement.'Going Private', Love.P, *The Evening Post*, 26 October 1996,p17.

57 This is taking into consideration an adjusted income to compensate for inflation

58 This figure is projected off an increase in the average elderly yearly income which had been adjusted for inflation at 3 percent over 10 years. The average income for the elderly in 1997 is $12,177 this would then rise to $13000 per year by 2008. The 70 percent figure is taken from the adjusted figure.

> important than ever for individuals to continue with private health insurance.'[59]

It is certainly not exaggerating to suggest that in the next few years health care policies for the elderly will be reduced down to only bare essential coverage for those financially able enough to afford the luxury of even reduced cover. The projected premium increases are at a level which many elderly would simply not be able to afford to purchase. It can be seen that if such trends continue complete health cover will be reserved only for the wealthy, turning the old proverb "health is wealth" on its head.

Discrimination against the elderly is a prominent problem amongst some insurance companies who have set age restrictions on the elderly's ability to take out policies. In the past, most health insurers refused to accept new members above a certain age. However, the introduction of the *Human Rights Act* 1993 means that it is against the law for an insurance company to deny a person coverage due to their age. Yet despite this legislation a number of companies still persist in setting limits. 'I was accepted for cover but my husband was refused because he was 8 months over the age limit. I consider that discriminatory.'[60]

Farmers mutual group (FMG), a small predominantly rural insurer, has an age limit of sixty-five years. At PSIS, applicants must be under sixty-five years to obtain the health care policy and under 70 years of age to join Surgical Care. These insurers are clearly discriminating on the basis of age.[61] It is quite obvious, in most cases, that discrimination has not been eliminated by the introduction of the Act but rather mutated from exclusion by age to exclusion by price. Rising premiums costs which force the elderly to either cancel or downsize their polices is one way of alleviating the problems of growing numbers and increasing needs. Discrimination is a necessary way for the companies to control the burgeoning numbers of elderly needing cover and the corresponding demand for services. Considering the amount of increased pressure on the private insurance market, the insurance companies were asked about the reliability of the private insurance market for making health care coverage accessible to those sixty-five and over now and when their numbers start rising in the future. Unimed's branch manager expressed his personal opinion:

> 'I am really concerned about my elderly members and my inability to financially assist them [with their health care policies]. In the past the costs have been cross subsidised by younger people, however competition with other companies under cutting premiums means we can no longer do this.'[62]

Despite the paternalistic concern it is the insurance companies which make the decisions to raise the premiums. However, the insurance companies argue that it is only out of necessity

---

59 Dr Hylton Le Grice, Chairman of Southern Cross, cited in the SC Annual Report 1997,p.3.
60 Comment in HC Survey 1997, by elderly refer Appendix B.
61 Consumer magazine, 14 July 1997, p.29.
62 M.Dermott Interview,1997.

that premiums are increasing and indeed doing so is detrimental not only to the premium holder but also to the companies themselves. The problem is circular according to the branch manager of Southern Cross.

> 'When we are forced to increase premiums due to increased claims [as services once provided in the public sector are being cut]. Those who have not claimed or are in relatively good health tend to cancel their policies, hence reducing the pool [of policy holders from which to draw premiums]. The problem is that the company is left with those who are of poor health and are frequent users, this in turn perpetuates increasing costs which have to be passed on through premium rises.'[63]

Unimed's branch manager made a similar observation in stating that:

> 'Each time you increase your premiums you burn off a layer of policy holders, the so called 'valuable policy holder' [those who are infrequent claimers] the bad risks stay and continue to claim - everyone loses out'.[64]

These comments demonstrate the belief held by insurance companies that they too are the victims of the governments restructuring plans. At present insurance companies contend that they are feeling the squeeze and are likely to be in this position for some time. A number of managers expressed concern over the lack of dialogue between themselves and government as to the future direction of health care funding. Despite these concerns the insurance companies are definitely better off than their policy holders. Profit margins do appear tight, however, Southern Cross announced in 1996 that the rate of return on claims was 98 cents to every 1 dollar paid in premiums. An across the board increase in premiums of 12 percent has seen this margin increase in 1997 to 96 cents to every 1 dollar received in premium payments. A preferable margin, according to McCloud, is 9 cents.[65]

Insurance companies will not have to struggle to keep up with the reforming system forever. While the private insurance market is going through a transitional period premiums are being continuously increased so as to return some operating margin. However, once the health sector settles down and the government has withdrawn to its desired level of input, the companies will play a vital and lucrative role in providing health care to the public. Private insurance will become a necessity in obtain adequate and timely access to health care and ultimately public health care will become the poor man's alternative.[66]

Despite the earning potential for the private insurance market, New Zealand health insurance is dominated by a non profit organisation. Southern Cross is a not-for-profit company registered under *The Friendly Society Act*, therefore, its motive is not as

---

63 F.McCloud, Interview, 1997.
64 M.Dermott Interview, 1997.
65 F.McCloud, Interview,1997.
66 K. Batchelor, 'Health for the rich only: Coney', *The Daily News*, 10 October 1997.

economically inclined as other profit making insurance companies. At Southern Cross members are considered share holders with surpluses reinvested and kept as reserves to supplement premium rises. However, the "not-for-profit" nature of New Zealand's largest health insurer warrants a more thorough investigation. When the branch manager of SC was asked about the excess earned, she said that it was invested as 'shareholders funds' and was held as a "buffer against increasing premium rates".[67] Knowing that premiums have been steadily increasing at around 12 percent each year one would expect reserves to be correspondingly decreasing in accordance with the stated purpose of the excess fund. However, an inspection into the company's 1997 annual report found that in fact as premiums have been steadily increasing so too have the reserves (see figure 27). Not only have the reserves been increasing, but they have more than doubled from $86.6 million in 1992 to $197.4 million in 1997.

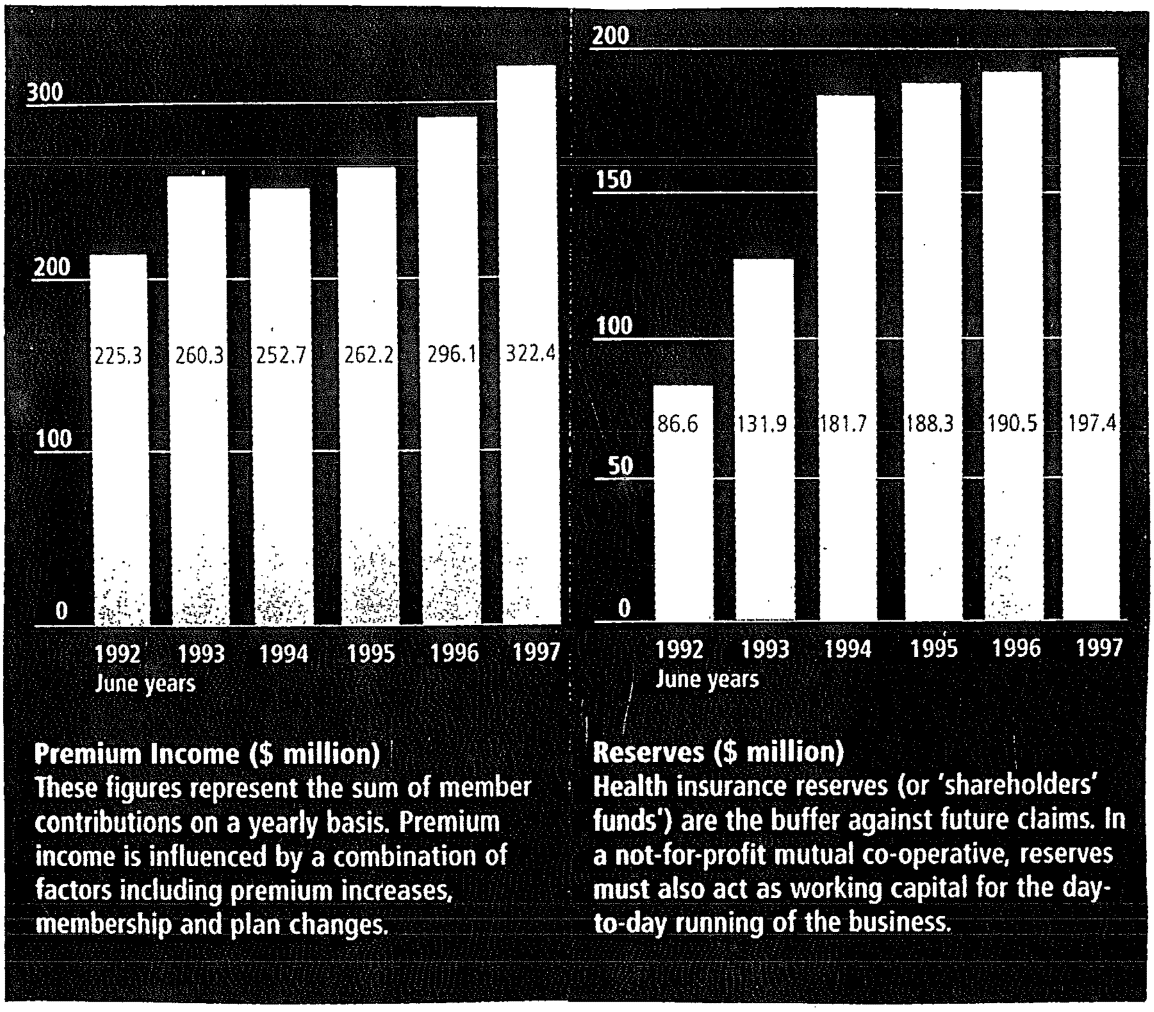

Figure 25. Southern Cross's financial figures

Source: Southern Cross Annual Report 1997

[67] F McCloud interview, 1997.

Arguably, it is possible that the insurance companies are increasing the reserves in expectation of future increases in claims. However, the company has been dealing with sharp increases in claims ever since the reforms began and has so far refrained from using the reserve funds to buffer against raising premiums. There is no indication that this practice will alter given that claims show no sign of abating. The result is that the company is making a profit but failing to channel it back as intended as a benefit to its members in the form of protection from premium hikes. It is a dubious situation which appears to bolster the financial credibility of the company, but actually undermines the non profit objective.

Experimental Public Policy - the results

The current model has failed to evolve into what the government intended. There was supposed to be an internal market, i.e., public hospitals competing against each other and against the private sector. That never eventuated and last year's coalition agreement effectively abandoned the plan in favour of a transitional health funding authority. Another critical element of the reforms was supposed to be the defining of a list of core public health services so that all New Zealanders knew exactly which expenses they would be responsible for at the point of delivery. That plan wound up in the too-hard basket. Without such a list, however, it is impossible for the health reform model to function properly. Neither has the radical idea of giving people entitlements ('vouchers') to spend as they wish on their own health care survived, except in the policy of the Act party. Perhaps the most unrealistic goal involved the plan for the CHEs were to make profits; quite extravagant profits if some ministers were to be believed. A policy U-turn stating that the CHEs are to be non-profit-making brings policy in line with reality.

Retreats, smokescreens and swerves mark the government's progress towards the health care system of which Treasury once dreamt. 'This country is now left, with a hybrid, half-commercialised, clumsily structured system resembling the original blueprint only in the way that a camel could be said to resemble a horse'.[68] The impacts of the experimental nature of the reforms have taken their greatest toll on the elderly. Nine main areas which have been addressed throughout this paper reflect the impact on this vulnerable and rapidly growing group. Below in point form are the main impediments;

- The increasing financial inaccessibility of health care in the private sector.
- The increasing inaccessibility of health care in the public sector.
- The increasing waiting lists in the public sector and the introduction of the booking system which results in many elderly being denied surgery altogether.

---

68 D.Welch,'The nation's health', *Listener*, 1 November, 1997

- The creation of apprehension and anxiety over the withdrawal of government funding in health care.
- Deterrence from private rest homes due to the expense.
- Increased pressure on families and the elderly due to asset and income testing in long stay private and public hospitals as well as rest homes
- A trend of reducing insurance cover due to cost, hence a further reduction in access to necessary health care.
- The closure of hospitals and the added concern with travelling and on-going care.
- Loss of family inheritances due to resources being diverted into paying health care costs.

These are all areas which have resulted from changes to the health care system and which have impacted on the elderly in varying degrees of intensity. All reflect the failure of the experiment conducted by the National government since the beginning of 1991.

Adjusting the Agenda for the New Millennium

It is clear that an adjustment to the current health care agenda is in need if the fundamental impediments to access are to be adequately addressed. One of the most compelling reasons for an adjustment is the fact the access problems are not specific to the elderly. Certain ethnic groups, in particular the Maori, and even individuals in the middle to lower socio economic levels are currently dealing with impediments to access.[69] Another important reason for adjusting the health care agenda is the rapid growth rate of the over sixty-five group (as highlighted in chapter two). By 2020 the elderly will have increased by 16.5 percent[70] so that one person in every five will be in defined as elderly.[71] Considering this the government is faced with the possibility of a large proportion of the population being heavily dependent on a system which is unable to cater for them.

With this in mind the two main areas of health care which need addressing are assessed. The first is the tension between the competing elements of access on the one hand and rationing of health care resources on the other. The second area involves the need to determine the appropriate proportions of public and private involvement in health care in order to alleviate and, ideally, prevent the problematic distribution outcomes.

Access Versus Rationing

Perhaps the most important question for domestic public policy in this decade is how to provide high quality health care to all citizens at a cost the country can afford. The government's answer has been to privatise and incorporate the market into the provision of

---

69 S.Coney, 'Despite the talk, little changes in health system', *Sunday Star Times*, 12 Janury 1997,p.5.
70 NZ Now 65+ Statistics NZ, Wellington, NZ 1995 p.14
71 Bolger in Taranki election speech June 1996

health care in order to bring about efficiency and contain potentially escalating costs for the government. Further, the government has been decreasing its input into public health for the last decade (as shown in chapter two). There is little doubt that the government is going to save vast amounts of money by bulk funding and withdrawing from major areas in health care like elective surgery. It is quite clear that we are living in a cost-driven society. However, there is debate amongst economists as to how much of the GDP should be apportioned to health care costs. Chapter two showed that relative to other countries New Zealand's expenditure on health care is in the bottom tier of the OECD countries. Despite this, rationing is seen as a paramount goal by the government even if it is not specifically articulated.

> 'Financial constraints also mean that priorities must be addressed. Demand for health care will always outstrip the resources available. It is more honest to define which services will be made available to all, rather than to continue to place patients on waiting lists where they may stay for years without treatment. Countries much richer than ours are having to face these issues. As a heavily indebted nation, New Zealand cannot avoid facing the limitations that its income imposes on it.'[72]

The fact is that there is not "an infinite pool of money to pour into it [health care]"[73] and technological advances in health care are not cheap. 'People now realise that health services have an insatiable appetite for money and we must put the brakes on somewhere.'[74] The point is that although technology is developing to meet the needs of the ageing population, the elderly themselves are not in a position to meet the huge funding requirements. Neither, it seems, is the government prepared to channel the requisite amounts into meeting these costs. As Mechanic states

> 'As people have learned to have high and more unrealistic expectations of medicine, demands for care for a variety of conditions, both major and minor, have accelerated. No nation that follows a sane public policy would facilitate the fulfilment of all perceptions of need that a demanding public might be willing to make. As in every other area of life, resources must be rationed.'[75]

Rationing decisions are difficult and politically unpopular as the survey results demonstrate. Figure 27 shows that while nearly 40 percent of the elderly conceded that

---

[72] *Your Health and the Public Health*, A statement of Government Health Policy by the Hon. Simon Upton Minister of Health, Crown, Wellington, July 1991.

[73] According to chief executive John O'Neill as cited in D.Welch,'The nation's health', *Listener*, 1 November, 1997.

[74] Organisation for Economic Co-operation and Development: *The reform of Health Care Systems; A Review of Seventeen OECD Countries*, France: Paris Cedex 16, 1994.

[75] D.Mechanic,1977. 'The Growth of Medical Technology and Bureaucracy: Implications of Medical Care.' Milbank Memorial Fund Quarterly, as cited in R.H.Blank, *Rationing Medicine*, Columbia University Press, New York 1988, p.87.

rationing was a necessary element of health care, 82 percent rejected the idea that they should be subjected to rationing (figure 28).

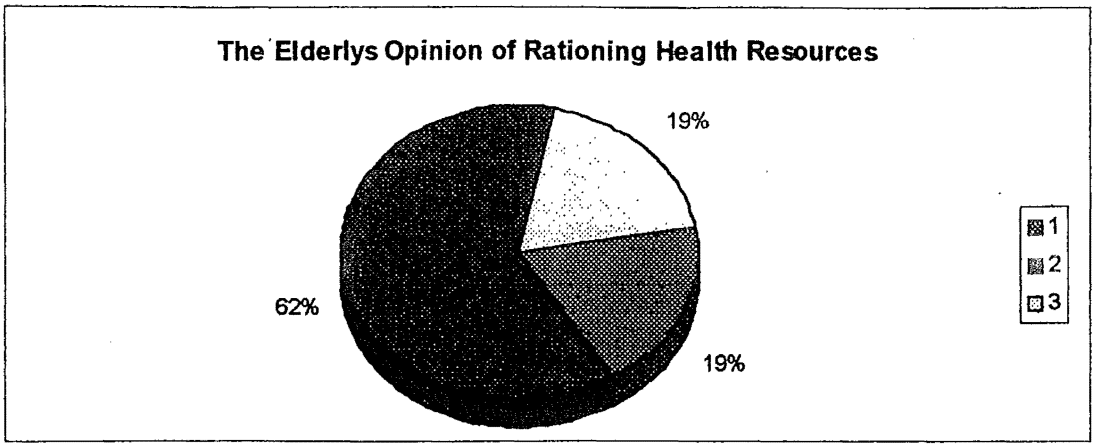

Figure 26 *Source:* **Health Care Case study of the Elderly 1997**

Legend:
19 percent of the elderly do believe in some form of health care rationing
19 percent do not necessarily agree with rationing but say it is inevitable
62 percent of elderly say no to the rationing of health care resources.

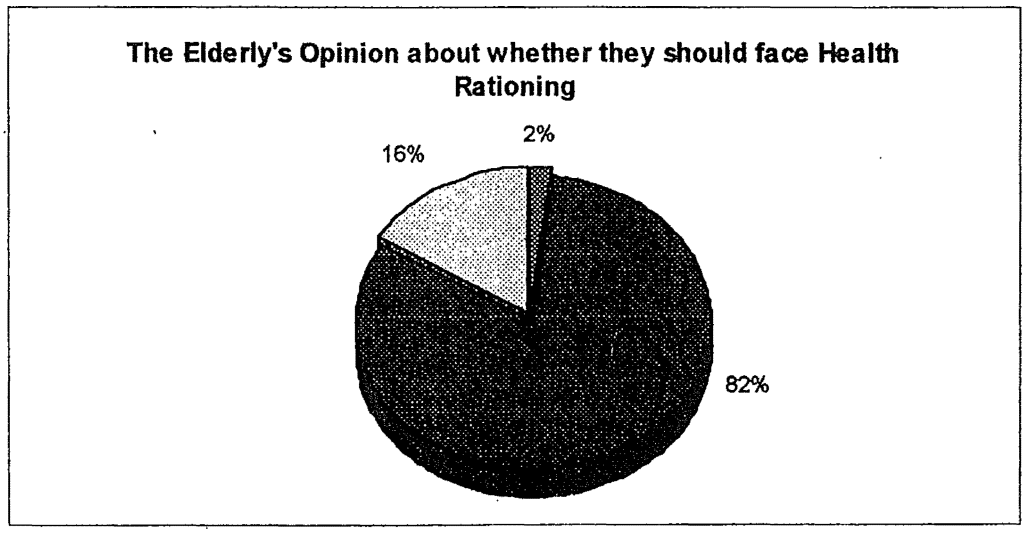

Figure 27 *Source:* **Health Care Case study of the Elderly 1997**

Legend:
2% thought they should face rationing,
16% said it was inevitable for all
82% believed the elderly should not be subjected to health care rationing

This indicates that while many elderly believe in the theory of rationing, very few are prepared to share in the responsibility of conserving medical resources. It may well be true that the elderly in New Zealand have an unreasonable expectation of what health care provision should be. However, this is not surprising considering that it they have experienced a lifetime of government funded care. Furthermore, this attitude may reflect the perception that they will bear the brunt of rationing since they are not regarded as productive members of society.

The predominate argument used by the government to justify rationing is efficiency. The question which arises in respect of this is what does "efficiency" mean in the context of health care. If one accedes to O'Neil's view "efficiency" is not the "culture of long corridors, lengthy stays and procedures, bumbling bureaucracy and boards...[but]...one that is professional and business-like, and crucially, more efficient in treating patients".[76] In achieving efficiency in this last area the government policy of rationing has seen the criterion for access shift from need to an ability to pay. It is this shift which has created a crisis for the elderly which was not in issue prior to the reforms. The changes introduced by the government have the potential to seriously undermine equity, a possibility which is becoming a critical concern for the groups most adversely affected. While the CHE's blueprint for the future focuses on providing a high standard of care and improving health through prevention and education, there is no mention of adequate distribution.[77] There is no doubt that as a country New Zealand has to live within its budget, however, this does not create a mandate to exclude large minorities from accessing much needed health care. Medical resources are scarce and are characterised by inelastic demand, but it is precisely this these attributes which make health care an inappropriate resource to open up to the competitive based private sector. Any market place which controls a limited resource with inelastic demand is a fertile environment for exploitation. Moreover, the most dangerous aspect of the reforms is that in the areas where the government has withdrawn there has been a corresponding removal of responsibility and accountability which has not be compensated for in the private insurance market.

The access/rationing dilemma is one which has plagued the United States system since it privatised health care in the 1930s. Considering the similarities to the New Zealand system, the American experience is of intense interest (see Chapter 2). Private hospital care was rationed by price and generally available only to those persons who could afford to pay their own way. Conversely, public hospital care was rationed to the poor on the basis of rigid 'means' tests. The result of this market allocation scheme was a dual or tiered system that produced inequalities in distribution as well as severe financial instability for hospitals. More importantly, the cost escalation of private hospital care forced many working and middle class people whose modest means disqualified them for public hospital care to forgo necessary

---

[76] Chief executive John O'Neill cited in D.Welch,'The nation's health', *Listener*, 1 November, 1997.
[77] According to chief executive John O'Neill as cited in Welch 1997.

treatment.[78] Although insurance coverage afforded widespread and substantially expanded access to hospital care, a significant minority of the population failed to be served by the new market situation in the United States. The lower middle class and the poor could seldom obtain adequate insurance coverage. Also, the greater need of the elderly for health care made them bad risks, thus pricing all but the most wealthy out of the market. In 1962, approximately half of all persons over the age of sixty-five had no insurance for hospital care, double the proportion among persons under sixty-five. Because of their greater need for hospital care, many elderly persons were without health insurance protection.[79]

The resemblance to the current direction of the New Zealand GC system is disturbing. While rationing is critical, the need to prevent barriers to access arising out of private insurance market involvement is fundamental. In order to achieve this the government must intervene in the market process even though this contravenes the theory of unfettered market intervention. Health care is a resource unlike any other in that it provides essential life preserving services. The private insurance market are proving inadequate in fulfilling their adopted role and if the government continues to ignore the evidence showing the inability of the private insurance markets to provide non discriminatory access to the elderly, it will fail in its fundamental role of socialy responsibility.

Public and Private Involvement - the necessary combination

From the elderly's perspective there are not many positive aspects to things the current health care system. Health care was free and easy to obtain now it is expensive and increasingly difficult to access. People were given the opportunity in the case study to express any thoughts or experiences they had with the health care sector. Any positive comments were in relation to acute hospital care and emergency services which is an area currently unscathed by reforms.[80]

---

[78] R.E.Brown, 1983, 'The Rationing of Hospital Care,'R In President's Commission for the Study of Ethical Prolems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care, vol.3. Washington, D.C, GPO. as cited in R.H.Blank, *Rationing Medicine*, Columbia University Press, New York 1988, p.87.

[79] Brown, 1983, as cited in R.H.Blank, *Rationing Medicine*, Columbia University Press, New York 1988, p.87.

[80] In a recent article *The Christchurch Mail*, 12 January 1998, 'Thumbs up for Health', a high degree of satisfaction was reported for customers using Christchurch hospital. Those using hospital services were asked to rate their level of satisfaction with the way staff handled various aspects of service. In all categories high percentages of customers rated the services as good or very good. Eighty-nine percent rated the hospital's performance in dealing with patient needs at admission as good or very good; 88% rated staff availablility and courtesy as good or very good; and 86% rated their satisfaction with the way patient needs were met as good or very good. Also rated as good or very good by 86% were quality of facilities and 82% saw communication between departments as good or better. However, only 75% rated discharge information as good or very good. Asked if they would come back, 94 percent said yes. There is no doubt that once patients are in hospitals in New Zealand they get the best treatment available, what is the issue rather is that many in need are not getting there. This article which talks of patients as 'customers' conducted a survey which did not address any issue

> '..I get excellent service from med[ical] centre, G.P, Oncology, Pathology, Haemotology, for my post OP and diagnostic follow up. A good Team!'[81]

> '...I have heart problems and have gone to A&E [accident & Emergency] at the public hospital I had excellent support but they were far too busy - not enough staff. If the government continues to tax us all (GST) they should support us (the public) with adequate well staffed [and well] run public hospitals - If we privatise like the USA God help us all.'[82]

The case study offered some evidence of where government intervention or regulation is required to provide adequate and accessible health care to the elderly. Six areas needing adjustment were identified;

- the escalating cost of resthome stays and the way that they are operated.
- the geographical distribution of the private health delivery network in the future.
- access to a base level of health insurance, including services such as elective surgery.
- the distribution of core services which will be available based on realistic asset and means testing.
- the implementation of a 'safety net' for those financial unable to access essential health care services.
- control of the insurance market and the monitoring of discriminatory behaviour, such as continuous premium increases for certain high risk groups, age limits and future genetic discrimination.

Market advocates will argue that in order to have a truly effective market system then there must be minimal government intervention. In spite of this the government acknowledges that it needs to manage the competitive element in health care, however, it is not acting accordingly. The government's determined cost cutting measures are creating a concern that the government will bequeath too much of the health care system to the private sector. Essentially the problem is one of funding. 'The core concern that people have is the question of funding, and much will flow from the rectification of that problem'.[83] The government has cut costs to the bone. Referendum campaigners are calling for an increase in government health spending to at least seven percent of GDP. That way, they claims, the government would have more money to give RHAs, the RHAs would pass the savings on to the CHEs and the CHEs would distribute it on. Public discontent would then subside. David Seedhouse, senior lecturer

---

that is in question in the health system, yet the title graced the front covers of a high circulated magizne in Christchurch with the title 'Thumbs up for Health' not only does the article have no substance it is misleading which begs the question that it is designed to convey a messege which overrides real issues of concern in health.

81 Comments made by an elderly person who was surveyed in Christhurch 2 October 1997.

82 Comments made by an elderly person who was surveyed in Christhurch 2 October 1997.

83 Comments made by former Auditor-General Brian Tyler, as cited in 'The nation's health', *Listener*, 1 November, 1997.

in medical ethics at Auckland University, rejects this claiming 'It will just make people think throwing money at it is the answer'. Like Alister Scott, of the Coalition for Public Health, he believes that our whole approach to health care must be reviewed in the context of a coherent social policy. But he sees no current mechanism for doing that, other than a change of heart by the government, and that is unlikely.

> 'We blew the whole thing up and now we have a bunch of fragments. And there aren't any established policies to put the bits back together. We've got the cathedral on the ground, but nobody's got a map of how you put the thing together'[84]

The backlash against the reforms suggests that, for most people, the whole point of electing governments is that they have a responsibility for to act in the best interests of the people. That is the social contract: you pay tax to the state and in return the state looks after you in various ways. If this belief is widespread then one would expect a reasonably astute government - one with a keen interest in being re-elected - to adapt accordingly. So far, however, there is no sign of major government concessions. If anything the new Prime Minister Jenny Shipley has indicated that she will further intensify the reforms. This is dangerous considering that an attack on a social service such as health affects the entire population in ways that are very difficult to compensate for. Arguably because the groups which form the bedrock of National's voting support are the ones who stand to benefit most from the current policy reforms, the government base support should not be eroded. However, to accept this is to assume that these people are all in the very high income bracket and that they are not influenced by elderly friends or family who are disadvantaged. The reforms will affect every New Zealander in some way even if they do not realise it yet. Because of this the health issue is not only one which could undermine the government's current public support, it also has the potential to haunt the National Party and NZ First in the future.

From a survival point of view, therefore, the government is arguably standing on a political minefield. However, in the environment of MMP it is very difficult to second guess election outcomes. Moreover, any U-turn in policy must involve an implicit admission that it had pursued unsound policy and created much hardship for the past seven years. Any judgement as to the merit or otherwise of the reforms aside, the disturbing fact is that the health reforms have to some extent been a paper exercise from the outset. In order to get them to function like private businesses CHEs were given artificial debt, therefore, whatever is achieved through further 'efficiency gains' may be meaningless except in terms of collateral damage. New Zealand could find itself with an 'efficient' health system boasting balanced

---

[84] Comments made by the former Director-General of Health George Salmond, cited in 'The nation's health', *Listener*, 1 November, 1997,p.20.

books, but suffering an inefficient society at large in which noticeable numbers of people suffer needlessly because their predicament cannot be accommodated or even comprehended by the cost-accounting mentality of the government. In the light of that prospect, a critic might be tempted to paraphrase Oscar Wilde and say, 'Efficiency is the name we give to our mistakes.'[85] It seems clearer and clearer, as Welsh recognises, that the machinery of market forces, so unstoppable in its advance through various parts of society for more than a decade, has finally run into something it can not shift, something profoundly unamenable to be run like a business and that most people want the state to stick around in a fairly meaningful way as far as public health is concerned.[86]

Conclusions

The first section of this chapter set out to assess the outcome of market incorporation in health care. The case study and interviews were used as evidence for this purpose. It was argued, first, that in order to achieve many of the market objectives, an essential variable was presupposed - the ability to pay. Results of the case study convey a picture of serious financial concern amongst the elderly over their ability to access adequate health care given the increasing financial instability resulting from a continuous rise in premiums and the on-going government withdrawal. The first set of market objectives, therefore, introduced a fundamental problem, the issue of financial accessibility.

Secondly, it has been argued that innovation in the market can mean transferring a loss onto someone else in very subtle ways. This was manifested in the fact that rising premiums meant many elderly were being forced to cancel long held insurance policies. The insurance companies invented a scheme whereby those who were unable to pay the higher costs could scale down their existing cover. This further reduces the elderly's access to health care and, at the same time, reduces the private insurance company's liability to pay.

Thirdly, it has been argued that there is a danger of professional aptitude being subordinated to price as insurance companies encourage surgeons to undercut each other. This is an aspect of the type of behaviour a market environment can bring about. Such behaviour is not incited in the interests of the patient but rather in the interests of return and capital gain.

Fourthly, I have questioned the notion that rationing by price is a fairer system of meeting need than other alternatives, such as public waiting lists and urgency. There is nothing fair about being denied health care because a person is unable to pay for it. However, those of the neo-liberal view find that a policy of rationing is more effective economically because the wealthy retain more in their pockets as the public take individual responsibility for health care payment.

---

[85] D. Welch, 'The nation's health', *Listener*, 1 November, 1997,p.21.
[86] Welch, 'The nation's health', 1997.

Finally, I have questioned the assumption that the private sector will to fill the void left by public withdrawal. The closing of non viable public hospitals will not result in the private sector moving in to these regions. The more likely outcome is a clustering of private hospitals and medical clinics in the higher populated cities. This then creates geographical maldistribution which is ultimately extremely inconvenient to rural populations and can be dangerous in emergencies.

The second section of this chapter assessed the presence of moral hazard and adverse selection. Results showed that the elderly did not have the attitudes towards their insurance policies that would suggest the presence of moral hazard. Evidence of this was found in case study questions and interviews from the insurance companies. This was however, relatively difficult to gauge due to a couple of factors. First, some elderly may not have been truthful in the case study and second, the use of insurance has skyrocketed due to public cutbacks making it difficult to gauge moral hazard through conventional methods. Considerable weight was assigned to comments made by the insurance companies that moral hazard plays an insignificant role in the elderly's attitude to health care consumption. In fact, it highlighted the increased level of genuine need for services offered through the insurance companies. From the insurance companies perspective the critical issue affecting the elderly was adverse selection as it added to the upward direction of premium prices and the increasing inaccessibility for the elderly.

The third section investigated the capability of the insurance companies in providing health care needs to the elderly in the new millennium. Under the current direction there are major distributional concerns. Premium costs now are too expensive for many elderly and future projections predict that the issue of inaccessibility will only deteriorate. Age had once been used as a way for the private sector to discrimination against the elderly, however, recent legislation has brought about a change so that price has now become the main means of denying many elderly health care protection.

The fourth and final section examined the need to adjust the health care agenda for the new millennium. The access/rationing dilemma was weighed and it was argued that while rationing is necessary, the government must continue to play a role in ensuring that access to health care is available to the elderly. The fact that the management of health care system has the potential to undermine the government's support should make the issue as important for the government as it is for those affected by its actions. Because the basis of rationing has been transferred from need to an ability to pay, the questions of access and equality are relevant not only for the elderly, but for all New Zealanders.

Conclusion

Implications of Private Involvement in Health Care for the Elderly, Now and In the Next Millennium

The conclusion of this thesis is not a solution to the system's ills, neither is it a policy proposal. It is, however, a warning to the policy makers and to government that its decision to ration health resources through a competitive market comes with a high cost to society, in particular to the elderly. This thesis has addressed fundamental issues surrounding the implications of the competitive market in health care on the elderly. It has shown that the effect is real and critical.

Research for this thesis was conducted at two levels. The first level was concerned with formulating a theoretical framework for studying New Zealand's dynamic health care environment. In doing so the benefits of incorporating the market principles into health care were analysed and, conversely, arguments against such incorporation were elucidated. This drew on the works of several theorists, particularly Donaldson and Gerald, and Harris and Seldon. In chapter 1 it was established on theoretical grounds that, first, while there was strong support by economists for the incorporation of market principles in health care, there was an equal number of economists who thought otherwise. This shows that support for such a transformation is very much a debatable issue and, in fact, the whole validity of the reform process, can be questioned considering the lack of empirical evidence internationally, as well as the lack of comprehensive support by professionals. This then makes the market reforms to New Zealand's system all the more experimental in its nature. Second, while the intent has not been to argue along the lines of 'state verse the market,' this did not remove the obligation to critique market advantages against market failures. This was highlighted in the second level of research, which conducted an empirical test of a number of theoretical propositions. The first hypothesis postulated that if the current involvement of the private sector continues unabated into the next millennium then New Zealands largest growing population group, those over 65 will have limited access to essential health care.

The so called advantages of the market place were examined in chapter five with the following conclusions reached. The first finding ascertained that in order to achieve any of the market objectives, the ability of the elderly to pay was presupposed. The case study supported this by conveying serious financial concern amongst the elderly brought on by them failing to be able to finance continuously rising insurance premiums while on fixed incomes. It was determined that over 60 percent of elderly surveyed placed financial accessibility of health insurance at the lowest end of the access spectrum while only 18 percent claimed it to be most accessible to them. With the government withdrawing its support in providing elective surgery the private sector is left to provide essential health resources required by elderly. The public system is in continual decline evidenced by funding data over the last decade as well as the fact that of those surveyed who had insurance cover, a staggering 80 percent had lodged a claim in the last 12 months. Those who are unable to afford insurance go on the every growing public waiting lists. The issue is that in order to be assured of essential and timely health care the elderly need to take out private health insurance, the problem is that an increasing number are unable to due to financial cost.

Further, skyrocketing premiums are forcing many, especially those who have had policies for long duration's (over 20 years) to cancel them. So while entry into the market is critical to gain access, both new policy holders and established holders are having to drop out. While demand is inelastic price is able to rise steadily for some time before any real change is noticed, however this decline, especially with the elderly is already evident.

Two fundamental obstacles are likely to be present in the future if the government continue to increase the role of the private sector as providers of elective care. First, is the clustering private facilities in only the economically viable areas. By closing public hospitals due to non-viability the private sector is unlikely to be encouraged to move into these regions, the more likely outcome is a clustering of private hospitals and medical clinics in the higher populated cities where there is certainty of income, as is currently occurring. This then creates geographical maldistribution issues which are extremely inconvenient to rural populations, especially those who need on going care. With limited transport means in many cases, this will only add to the cost and inconvenience, not to mention discomfort the elderly must endure when seeking health care. Such a situation occurred in the United States, prompting the government

to enter the marketplace to correct the geographical maldistribtion of hospital beds caused by private companies moving hospitals to more wealthy suburban areas.[1]

The second fundamental obstacle is the private sector's capitalisation on the growing needs of the elderly for long term care. With the government's gradual withdrawal form providing public rest homes, there has been tremendous development by the private sector in this area. While subsidised by the government, it recoups this cost through its policy of asset and income testing on the elderly, which is priced on average at around $600 dollars per week, a couple would need around $1000 ~ $1100 a week to fund the care with many forced to sell their homes to meet the bills. The intention of this policy is twofold, first to transfer the responsibility of the elderly back onto their families, and to make the user pays system relieve the government in part of the growing elderly burden. The reality of this, however, is greater stress on families and relationships as they are forced to juggle work commitments with elderly care, or with pressure being put on them with eroding inheritances and resentment building toward their parents for using up the families capital resources. Evidence shows that in the last few years there has been increases in elderly abuse cases reported, while no direct correlation can be made between the problems and the increasing numbers in the community it is certainly a logical conclusion to draw.

A society is judged on how it treats its most vulnerable members and these include the young, the old and the sick. But it also can be measured according to how honestly it faces up to the most difficult problems. New Zealand needs to work out how precious, limited health funds are best spent. Weighing up the competing needs of different generations is part of that. A second hypothesis postulates that the government's shift from a 'social equity model' in health care provision to one based on 'competitive markets' favours certain minority groups while disadvantaging the largest growing group, the elderly. This was tested empirically through the survey conducted of the elderly and by analysing the relationship between access and rationing. The phenomenon of rationing should be seen as the fundamental motive by the government in incorporating market competition into the health system, as it cuts the governments expenditure by transferring the cost directly to the individual. The government has taken to changing the direction of public policy on advice from international bodies, with justification derived from the argument of efficiency. But for whom will it be more efficient? At most to those in the higher socio economic group. Such a transformation gives credence to

---

[1] R.H.Blank, *Rationing Medicine*, Columbia University Press, New York 1988,p.98

Evans redistribution theory, which purports that part of the agenda behind market based health care reform is in effect to transfer the cost away form the wealthy and on to the individual user regardless of their financial position. By cutting taxes, the higher income earners keep far more of their disposable income. They effectively only pay for the health care they want through insurance, and not for a handful of others, which include the low socio groups, the dispossessed the young and elderly. So it seems the approach taken towards rationing is one based on the self-interested neo-liberalists view. Income distribution is an issue so sensitive and important that it arouses intense political and social passions in all societies and New Zealand is no exception. There is concern that the burden of economic adjustment has not been fairly carried out, with those benefiting most having high disposable incomes.

The government has effectively moved rationing from the sphere of access by need to the sphere of access based on an ability to pay criteria. This is a critical change in the allocation of health care resources to New Zealanders and threatens to put equity at risk. As this thesis has revealed many elderly are being denied essential health care now and many are likely to in the future under the current direction. The rationing argument raises the issue of access verse the future cost to government by rapidly increasing numbers of elderly, and their projected burden on the state in the next millennium. As the elderly over 60 make up over 16 percent of the population and use over 40 percent of health care resources, the issue of who is to pay becomes critical. Rationing by price under the competitive market approach has been implemented in an attempt to transfer and in effect reduce the use of health resources. These resources had previously been rationed on the basis of need, with patients being filtered through long public waiting lists. Now the individual is being made responsible for their own health care needs. For the majority of elderly who are on fixed low income, such a change is unplanned and unbudgeted for, leaving them financially vulnerably, reducing independence and dignity in there old age.

The third hypothesis postulated that private insurance companies are not suitable for providing the elderly with the necessary health care that they require, now or in the new millennium, unless changes are made. Under the current directions there are major distributional concerns. Premium costs are currently to expensive for many elderly and future projections see the situation worsening. Age had once been used as a way for the private sector to discrimination against the elderly, however reforms have changed this, now price has become the main means of denying many elderly health care protection.

Companies are adaptable to changing situations, with massive increases in claims on them due to the publics withdrawal, they have put up the cost of premiums to off set this and keep margins where they want them. The result as pointed out is the unaffordability for the elderly, the companies solution for those unable to pay the higher costs, is to scaled down their existing cover. This meant that elderly were getting less for paying more further decreasing there access to essential health care with insurance companies at the same time reducing their company's liability to pay. This is not the only concern, evidence revealed that surgeons were undercutting quotes bought on by company monopoly pressure in bringing prices down. Such behaviour is not being done in the interests of the patient but rather in the interests of a return from the to these companies.

Interestingly, one of the conventional weaknesses of the insurance market was not as prevalent as the theory had suggested it maybe. The testing of moral hazard and adverse selection, showed that the elderly did not have the type of attitude towards their insurance that would suggest the presence of moral hazard. Evidence of this was found in survey questions and interviews from the insurance companies. This was however, relatively difficult to gauge due to a couple of factors, first the elderly may not have been inclined to put down in the survey their true practice, and second, the use of insurance has skyrocketed making it difficult to gauge through the conventional method of usage. The evidence lent itself on the weight of comments by the insurance companies that moral hazard plays an insignificant role in the elderly's attitude to health care consumption. Despite these limitations, some of the findings were of general significance and importance, by highlighting the increased level on genuine need for services offered through the insurance companies. Adverse selection with the elderly on the other hand was seen to be a serious issue for the insurance companies. Adding to the upward direction of premium prices and the increasing inaccessibility for the elderly. The trends found here were indeed concerning only adding increasing evidence as to the problems that providing health care through private insurance companies brings about.

What of the experimental nature of the reforms and the impact on the elderly? Pressure by the Business Roundtable on the government to implement reforms saw widespread objectives laid down. The results however can only be said to be riddled with failure from a social perspective. At the micro level the empirical evidence of the case study of the elderly is testimony to the out come of the experiment and its chronic inadequacies in being able to provide health care equitably to the elderly. The fifth and final section looked towards adjusting the agenda in health care for the new millennium. The dilemma of providing access and

rationing health resources were weighed up, the result were that since the reforms the health care system has been put into a crisis, a crisis due to a withdrawal of government funding and slashing of the public's health budget, in the process closing effective and essential hospitals. The introduction of the private sector has meant that the basis of rationing has been transferred from that of need, to that of an ability to pay, and this situation is inequitable for the majority of New Zealanders not just the elderly.

Against the theoretical base of competitive market, this thesis has shown that the involvement of the private sector in providing health care to the elderly under the principles of the competitive market has created a serious access issue. Due to the fact that the elderly are growing at the rate they are, this is an issue of significant concern to both the elderly and wider society. If analysts misinterpret economic theory as applied to health - by assuming that market forces are necessarily superior to alternative policies in every sphere and that other tools of the trade neatly translate to health care - then they will blind themselves to policy options that might actually be best at enhancing society's welfare, many of which simply do not fall out of the conventional, demand driven competitive model. Market forces may indeed have a prominent place in health care organisation and delivery, but, as I have tried to show, when the private sector is made responsible for the provision of health resources it is not a paternalistic player concerned with issues like equity and accessibility but rather dictated by getting a return from the market environment, regardless of the cost to society's most vulnerable. In an era where the government wants less responsibility for its citizen's welfare, and is determined to withdraw the state from such important social policy areas making families and communities more accountable, it is perhaps more important than ever that the issues addressed by this thesis are recognised and dealt with. Otherwise we may find ourselves in a society where the class system is defined, not only from a financial basis, but from longevity as well.

References

***Newspapers Articles*:**

Anderton J, 'Health Already Private', *The Truth*, 18 April 1997.

Anderton J, 'Operation Kiwicare', *The Truth*, 23 Aug 1996.

Alexander M, 'Cut Price Surgeons Preferred', *Sunday Star Times*, 27 July 1997.

Bailey G, 'Aetna Insurance for Elderly $2000 a Year' *The Evening Post*, 11 September 1996.

Bailey G, 'Too late to Save Mum's Nest Egg', *The Evening Post*, 27 June 1997.

Batchelor K, 'Health for the Rich Only', *The Daily News*, 10 October 1997

Bates P, 'Needs Matched with Best of Care', *Waikato Times*, 29 August 1997.

Bolger J 'Government moves to wrest back initiative on health issues', *The Dominion*, 9 Oct 1997.

Cave S, 'Health Insurers "Lazy"', *Sunday Star Times*, 4 May 1997.

Clifton J, 'Effective Health', *Listener*, 22 March 1997.

Coney S, 'Despite the Talk, Little Changes in Health System', *Sunday Star Times*, 12 January 1997.

Coney S, 'Polls Suggest Health is the One Issue That Could Swing This Election', *Sunday Star Times*, 15 September 1996.

Forde R, 'No Bed for Dying War Wdow', *The Evening Standard*, 4 Oct 1997.

Guyan C, 'Hospitals not Viable, Face Cuts', *The Evening Post*, 1 September 1997.

Henderson M, 'Employer Help with Juggling Act is Vital', *Sunday Star Times*, 13 July 1997.

Holloway B, 'Health Insurer Raises Premiums', *Waikato Times*, 26 May 1997.

Hughs.A, 'Insurance picks up the tab' *The Evening Post*, 24 September 1996,p.6.

Kirk J, 'Eye surgeons investigated', *The Press*, 6 March 1997.

Levy L, 'Throwing Money at Hospitals Won't Cure Their Ills', *The National Business Review*, February 21 1997.

Love P, 'Going Private', *The Evening Post*, 26 October 1996.

MacDonald E, 'Sprinklers Too Dear - Rest Homes', *The Evening Post*, 23 June 1997.

Martin Y, 'Elderly Could Lose Abuse Relief Scheme', *Sunday Star Times*, 11 May 1997.

Mckendry.C, Muthumda.P, Health Expenditure trends in New Zealand, 1980-1992, Wellington Department of Health, 1993.

Moore M, 'Cruel Health Hoax', *The Sunday News*, 28 July 1996.

Orsman B, 'Ministry Attacks Health Decision', *New Zealand Herald*, 12 April 1997.

Powell I, 'Public Health Privatisaion Trend Concern', *The Dominion*, 21 May 1997.

Saunders J, 'The Nation with a Heart of Stone' *The Evening Standard*, 8 Febuary 1997.

Schere .K, 'Voters Most Tender on Fate of Change-Weary Hospitals', *The Evening Post*, 3 September 1996.

Sheeran G, 'Private health costs sure to rise', *Sunday Star Times*, 1 June 1997

Sheeran G, 'Asset Testing Still a Reality; Budget's 'Good News' Affects Very Few', *Sunday Star Times*, 6 July 1997.

Van de Bergh R, 'High cost blamed for health insurance fall', *The Dominion*, 19 November 1996, p.10.

Welch D, 'The nation's health', *Listnener*, 1 1997, Pp18-21.

Whitney.C, 'After a decade of Thatcherism; Have British values altered, New York Times, June 9 1991.

'Thumbs up for health', *The Christchurch Mail*, 12 January 1998.

'Population changes predicted' *The Star*, 6th June 1997,

'Health Insurance Spending Trebles', *The Dominion*, 9 January 1997.

RHA to Explain Fears Over Cost of Growth in Old Folks' Homes', *The Daily News*, 14 August 1997.

'Surgery Wait Lists 'Increased 39%', *The Dominion*, 5 Aug 1996.

'Health's Catch-22 Dilemma', *The Timaru Herald*, 13 Aug 1996.

'Taskforce Report on Ageing Lacks Impact', *Waikato Times*, 11 July 1997.

'Why change unit which is running smoothly?', *The Daily News*, 5 August 1997.

Interviews:

Kennard I, Pensioner, 10 June 1997, 11.45 at 64 Hansons Lane, Upper Riccarton, Christchurch.

Martin D, Manager of Unimed Christchurch, 1 October 1997, 10.00am at 163 Gloucester St, Christchurch.

McCloud F, Christchurch Branch Manager of Southern Cross, 26th September 1997, 11.00am at 148 Victoria St. Christchurch.

Hill.K, National Radio, 9am, 20th January 1997, Kim Hill, Interview with Professor Chris Ham.

Television:

Campell J, *3 National News*, TV3, 21 Oct 1997.

Fraser I, *Fraser*, TVNZ, Channel 1, 7 Oct 1997.

Hosking M, *Breakfast Show*, 22 October 1997and 21 Oct 1997.

New Zealand News Teletext, 18 Oct 1997.

3 Network News, TV3, 19 November 1997.

White J, *One Network News*, TVNZ Channel 1, 13 January 1998

Survey Data:

Shead A, *Health Care Survey of the Elderly* September/October 1997

Texts:

Bailey, D, *Towards Responsiveness - Objective Setting and Evaluation/Me Penapena - Nga Whainga Atu mo Nga Hua a Kitea Ana*, Prepared by the responsiveness unit of the state services commission committee membership (Wellington; The commission 1989).

Bayliss L *Prosperity Mislaid: Economic Failure in New Zealand and What Should be Done About it*, GP Publications, Wellington, 1994.

Blank R.H, *New Zealand Health Policy: A Comparative Study*, Oxford University Press, Auckland, 1994.

Blank R.H, *Rationing Medicine*, Columbia University Press, New York 1988.

Borren P and Maynard A, *Searching for the Holy Grail in the Antipodes: the Market Reform of the New Zealand Health Care System*, University of York, England, 1993.

Calnan M, Cant S, and Gabe J, *Going Private: Why People Pay for Their Health Care*, Open University Press, Great Britain, 1993

Cowan G.L, *Privatisation in the developing world*, Praeger Publishers, New York, 1990.

Donaldson C and Gerard K, *Economics of Health Care Financing: The Visible Hand*, Macmillan Press Ltd, Hong Kong, 1993.

Dow D.A, *Safeguarding the public health*, Postscript by the Ministry of Health, Victoria University Press, 1995.

Enthoven.AC, *The history and principles of managed competition*, London, 1991,Pp.24-48.

Gough I, and Steinberg A, *The Welfare State, Capitalism and Crisis*, Rutgers, United States, 1981, p.141-171.

Harris R and Seldon A, *Not from Benevolence*, Institute of Economic Affairs, London, 1977.

Hindess B, *Political Choice and Social Structure: An Analysis of Actors, Interests and Rationality*, Elgar/Gower, Brookfield, 1989.

McLachlan G. and Maynard A. (eds) *The Public/Private Mix for Health*, London; Nutfield Provincial Hospitals Trust 1982) essays by A.J.Culyer.

OECD, *The Reform of Health Care Systems, Study of 24 OECD Countries*, Paris,1992/1994.

Paton C, 'Health care financing:mobilising the money', *Health Policy and Management: The Healthcare Agenda in a British Political Context*, Chapman & Hall, London, 1996.

Poutasi K.O, 'Comparing Health Expenditure, letter NZ Med J 1996;109:325-6

Reinhardt.U, *West Germany's health care and Health insurance system*, 'Combining Universial Access with cost control', Washington, 1990.

Scarpaco J.L, *Health Services Privatisation in Industrial Societies*, Rutgers University Press, New Brunswick, 1989.

Scollay R and St John S, *Macroeconomics and the Contemporary New Zealand Economy*, Longman and Paul, Auckland, 1996.

Sharp A. *Leap into the dark: The Changing Role of the State in New Zealand Since 1984*, The Auckland University Press, Auckland, 1994.

New Zealand Business Roundtable, *From Recession to Recovery*, (Auckland; New Zealand Business Roundtable, 1992).

Upton *S, Your Health and the Public Health,* 'Green and White paper, Crown Publishing Service, Wellington, 1991.

Keene.L, *Health Reforms a Second Opinion,* Wellington; (Wellington Health Action Committee 1992)

White A and Taylor I, *The Social Effects of Free Market Policies*, Harvester/Wheatsheaf, London, 1995.

White J, *Competing Solutions: American health Care Proposals and International Experience*, Brookings Institution, Washington DC, 1995

Periodicals:

Abel-Smith B, *Who is the Odd Man Out*, 'The Experience of Western Europe in Containing the Cost of Health Care' Milbank Quarterly, 1985, p.63.

Blendon R.J, Morrison I, and Donelan K, 'Satisfaction with Health Systems in Ten Nations', *Health Affairs*, 1990, p.9.

Bollard.A, *The political economy of liberalisation in New Zealand,* Working Paper, New Zealand Institute of Economic Research, 1993, p.29.

Bowie.R, Uncovering the health expenditure myth, Health Relations, A Second Opinion, Health Economist, 1992.

Castles.F.G, Gerritsen.R and Vowles.J, 'Labour parties and Public policy transformation in Australia and New Zealand', *The Great Experiment* 1996,p.1.

Castles.G.F, Welfare state development in Southern europe', *West European Politics,* Vol 18, no.2, p.291.

Consumer Magazine, Vol. 361 14 July1997, p.22,

Day.R and Klein.B, *The Politics of modernisation,* 'Britian's National Service in the 1980s', 1989.

Enthoven A.C, 'What Can Europeans Learn from Americans about Financing and Organization of Medical Care?' *Health Care Financing Review,* Vol.11,p.49.

Evans R.G, 'Going for the Gold: The Redistributive Agenda behind Market-Based Health Care Reform', *Journal of Health Politics, Policy and Law,* 22(2) April 1997, p.453.

Evans.R.G, 'Public health insurance: the collective purchase of individual care, *Health Policy,* no.7, 1987, Pp.115-134.

Flynn T, 'The New Right and Social Policy', *Policy and Politics,* Macmillan,1989, 17, pp 97-109.

Fuchs.V.R, 'Economics, Values and Health Care Reform,' *American Economic Review,* 1996, Vol24,p.86.

Green D.G, *Working Class Patients and the Medical Establishment,* Gower, Aldershot, 1985.

Gerdtham U.G and Jonsson B, 'How Does Canada Do It? A Comparison of Expenditures for Physicians' Services in the United States and Canada', *New England Journal of Medicine,* 1991 Vol.323, Pp.884-890.

Inge M, 'Elective Surgery Access Restricted to Wealthy', *New Zealand Doctor* September 1997.

James.C, New Territory, Bridget Williams Books, Wellington, 1992.p139.

Kawachi.I, 'The American connection', Health reforms, *A second opinion*, 1992.

Kelsey.J, *Rolling back the state*, Bridget Williams Book, Wellington, 1993,p.137.

Kerr.J, 'Achieving a positive economic direction in Business, Roundtable, 'From recession to recovery', September 1992.

Neutze J.M and White H.D, 'Comparing Health Expenditures', *New Zealand Medical Journal*, (1996) 109 July-Dec.

O'Brien.M and Wilkes.C, *The Tradegdy of the Market*, 'A social experiment in New Zealand, The Dunmore Press, Palmerston North, p.171.

Pomae.E.W, and De Boer.G.M, *Towards Responsiveness, objective setting and evaluation/ Me Penapena - Nga Whaing atu mo nga hua a kitea ana*, 1989.

Rice T, 'Can Markets Give Us the Health System We Want?' *Journal of Health Politics, Policy and Law*, Duke University Press, Vol 22, No.2, April 1997.

Wildavsky A, 'Doing Better and Feeling Worse: The Political Pathology of Health Policy', *Daedalus*,1977, Pp.105-124.

Wagstaff.A and Van Doorstaer.E, 'Equity in the finance of health care, Some international comparisons', *Journal of Health Economics*, vol.11, 1992,Pp.361-387.

Thorpe K.E, 'Inside the Black Box of Administrative Costs', *Health Affairs*, 1992 p.11.

Zwanziger J and Auerbach R.R, Evaluating PPO Performance Using Prior Expenditure Data', *Medical Care*, 1991, p29.

Reports

Ashton T. et al. *Reforming the New Zealand Health System: Lessons from Other Countries.* Report of a Study Tour Sponsred by Health Boards, New Zealand, 1991.

Health care study group, Understanding the choices in health care reform, *Journal of Health Politics,* Policy and Law, Vol.19, 1994, p.499.

Le Grice H, *Southern Cross Annual Report* 1997.

Minister of Health, 1991, Your Health and the Public Health.

National Advisory Committee on Core Health and Disability Support Services, Fourth Annual Report, September 1995.

Richard.D, *Care for Older People in New Zealand,* A Report to the National Advisory Committee on Core Health and Disability Support Services, (Wellington; The Committee, 1995)

Scott.G, 'Health in the marketplace', *Health reforms a second opinion,* Wellington, Health Action Committee, 1992, p.17.

Statistics

New Zealand Now 65 Plus, Statistics New Zealand, Wellington, 1995.

OECD/CREDES, OECD Health Data 1996. Software for the Comparative Analysis of 27 Health System. Paris: OECD Health Policy Unit, 1996.

Statistics New Zealand, *Census of Population and Dwellings*, 1996

Upton.S, Health Policy, 'Your health and the public health' summary: a student of government health policy (Wellington; Minister of Health 1991).

Internet:

Kiwinet, Sunday Star times, 12 June 1997.

Appendix

University of Canterbury Health Care Survey of the Elderly

Interview with Insurance Company

UNIVERSITY OF CANTERBURY
HEALTH CARE SURVEY OF THE ELDERLY

Today's Date:

This survey is carried out for the purposes of Andrew Shead's masters thesis, any enquires please telephone: (03) 3667001 extn.8677
All data will be kept in strict confidence, no personal information will be given to any health insurance companies.

Please DO NOT put your name on this sheet.

Just tick the letter (e.g a) which best reflects your position and opinion

(N/A means not applicable)

Q1 What ethnic group do you associate yourself with:

a) Caucasian
b) Maori
c) Pacific Islander
d) Asian
e) Other

Q2 How would you describe your health status

a) ~ Poor
b) ~ Fair
c) ~ Average
d) ~ Good
e) ~ Excellent

Q3 What method of payment for Health Care is most preferable to you?

a) ~ Paying premiums for health insurance
b) ~ Paying through taxation
c) ~ Paying directly as you need it
d) ~ All of the above

Q4 Are you currently covered by Private Health Insurance?

~ Yes (Go to question 9)
~ No (Go to question 8)
~ Was, but cancelled my policy

Q5 For what reason did you cancel your policy?

a) because premiums rose?
b) because you did not feel it was worth having? (under utilised)
c) Other reason

.....

.....

Q6 For what period of time had you had, private insurance cover?

1<yrs 5<yrs 10<yrs 15<yrs 20<yrs 20+yrs

Q7 Have you been rejected for private health insurance, as a result of:

a) ~ health problems
b) ~ age
c) ~ gender
e) ~ N/A

*Q8 Have you used the Health Care system for something more than just a check up in the last:

a) ~ 6months
b) ~ 5yrs
c) ~ 10yrs or longer
d) ~ No *(Go to Q13)*

@ Was it elective surgery? (non-life threatening)

a) ~ Yes
b) ~ No

@Was it life saving surgery

a) ~ Yes
b) ~ No

@Did you have to go on a waiting list?

a) ~ Yes
✓b) ~ No

@ How long did you have to wait
✓a) ~ short wait
b) ~ >6months
c) ~ within 12months
d) ~ 18months or >

@ Was this satisfactory to you

✓a) Yes
b) No
c) Didn't mind

@ How did you pay for this?

a) How did you pay for this?
✓b) Out of your pocket
c) No payment paid for by the public health department
d) Other .....
.....

(Go to Q13)

*Q9 How long have you had private insurance cover?

1<yrs 5<yrs 10<yrs 15<yrs 20<yrs 20+yrs

Q10 Have you made a claim on your health insurance in the last

a)~ 6months
b)~ 12months
c)~ <2>
d)~ <5yrs
e)~ >5yrs

Q11 Would you have had the treatment if you did not have insurance, i.e paid for it out of your own personal pocket?

a)Yes
b)No

@ Do you believe you utilise the insurance coverage which you have?

a) Yes
b) No
c) I don't think of my insurance cover in this way

@What type of attitude do you have with regards to using the coverage you have:

a) Use it only when necessary
b) Don't use it enough
c) Use it 'So I get my moneys worth'

Q12 Are rising insurance premiums a concern for you?

a) Not a concern, it does not effect me
b) Is an increasing concern
c) If they rise to much more I will be forced to quit my policy

@ supposing premiums were to rise, when would you dis-continue your medical insurance coverage if at all?

Considering a rise of:

a) 20%
b) 30%
c) 60%
d) I would not dis-continue my medical insurance coverage, even if the cost of premiums continued to rise steadily.
e) Don't know - decide at the time

*Q13 Is 'ACCESS to services' in the Health Care system a concern for you?

a) Yes
b) No
c) No, because I have Private health insurance

Q14 Do you think that the governments reforms have made Health Care more or less accessible to you? (In that if you need care, it is easy to obtain).

a) ~ greatly improved accessibility
b) ~ more accessible
c) ~ no difference
d) ~ less accessible
e) ~ much less accessible

Q15 Do you believe the cost of Private health Insurance premiums is an impediment to Health Care services for yourself.

a)Yes
b)No

Q16 How accessible (finically) is private health insurance to you personally

1 2 **3** 4 5

(1 being most accessible & 5 being least)

Q17 Do you believe in some form of rationing of Health Care resources?

a) Yes
b) No
c) Inevitable

@ Should the elderly be the ones to face rationing measures?

a) Yes
b) No
c) Inevitable for all

Q18 What is the biggest concern for you with the current Health Care system

a) ~ The reduction in public funding for Health Care
b) ~ The rise of private involvement in Health Care namely Private Insurance Markets
c) ~ waiting lists for surgery
e) ~ Other.....
.....
.....
f) ~ Nothing is of concern for me regarding the Health Care system

Q19 Do you think it is suitable to have the majority of rest homes owned and operated in the private sector?

a) Yes
b) No
c) Not sure

Q20 From your experience, (considering your parents or yourself), do you think that the cost of staying in a rest home an impediment to using the care?

a) Yes
b) No
c) Not sure

Notes/General Comments:

End of Survey

Name of Company:

Name and title of person interviewed:

Date:

Time:

Location:

Interviews with Insurance Company

OBJECTIVE:

A quick interview of 20 mins on:

- There origins, the problems insurance companies face with issues such as Moral Hazard which is partly responsible for the increase in premiums and how to deal with this, for both the company and the individual.
- The reduction in government spending on public HC and the pressure this puts on the insurance companies to provide the necessary back stop for the public.
- Info on types of policy holders, the issue of an aging population and how this is to affect policy's of companies.

Here the objectives are to find out the following:

INTERVIEW QUESTIONS

Apart from things I can read in your prospectus, just ad lib some ideas here for me.

Start with some general questions:

Q What are the companies origins? (Briefly)

Q Does it have sister/brother companies overseas, the States, Australia, etc?

@ How successful have they been? (i.e market share etc)

@ What's this companies aim regarding market share.

Q With the increased reliance by the public on insurance companies to provide HC coverage does this mean expansion is immanent in the future?

yes/no

Explain?

Q Do you (the insurance company) think that moral hazard is a prevalent issue for you to take into consideration? (i.e is it a problem?) (Moral hazard, the change in attitude of an insured person towards their behaviour of consumption)

yes / no

@How can you deal with moral hazard, or safe guard against it?

Q What group in your opinion is the most likely to be responsible for committing moral hazard?

Q Introduction of no-claims bonuses, would this be one way to help solve the moral hazard problem? - do you employ this technique.

[To prevent moral hazard, Southern Cross introduced a 20 percent co-payment on its standard policy, and a list of maximum refunds which have been universally adhered to by private specialists, hospitals, and competitors alike. The small size of New Zealand's population, together with limited user-chargers, have in the past prevented private health insurers offering a more administratively expansive range of policies and premiums.]

Q What role do you see this company playing in the future as a provider of HC coverage to New Zealanders?

Q What is your policy for expansion into the market, if any?

@ What group are you to target?

@ Why?

Q What protection measure do you take to prevent people joining up just to have surgery etc?

Q Is the growth in the elderly going to be a problem for the company? (it is estimated that by the middle of next century 1 in 4 New Zealanders will be over 65).

@ How do you propose to deal with this?

@ Is this not seen as a problem or an untapped resource?

Q How does the government policies (namely the reforms) affect the company? negatively, beneficially or other wise? (i.e the decreasing of spending in the public sector making the demand for private provision increase).

@ What have you had to change to accommodate the reforms?

@ How do you perceive this? i.e a good/bad thing for the individual/the country as a whole?

@ How effective is implementing policies with varying chargers (i.e 80% refund on the cost of care and 50% coverage etc.) Does this go some way to solving the problem.

@ How great a problem do you perceive it to be?

Q What composition of people take out insurance with you? young, old, ethnic, low upper soci economic bracket?

Q What plans have you got in mind to target the Maori elderly for HC insurance? if at all, or are they not viable to insure?

Q Are certain groups simply not viable to insure against?

(like the elderly for example)

- So how do you deal with this?

Q Can you see a continuation of the trend in rising premiums into the new millennium?

@How can this be prevented if at all?

Q Are you a For Profit or non-profit company?

END OF SURVEY